# have you had the talk?™

# Toolkit

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Kern County 661-410-1010 / Antelope Valley 661-272-2355 / www.HaveTheTalkHoffmann.com

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# have you had the talk?™ TOOLKIT INTRODUCTION

## What is The Talk?

This is "The Talk" nobody talks about. You already know about the talk about sex and the one about drugs and the one about planning for college, retirement, and your last will and testament. But what about "The Talk" that helps you and the people you love navigate a medical event like a heart attack or stroke, cancer, a chronic illness like diabetes or Parkinson's, or a gradual decline in health and independence?

The **Have You Had the Talk** Campaign will help you get a conversation going with the people you love about the kind of care you'd want if ever faced with an illness or medical event where you have to rely on someone else to help you through it. This is the conversation we put off until there is an emergency. Then no one knows what to do or who to call. Think about it: if you suddenly needed the help of a loved one in a medical situation, do they know who your doctors are? What prescriptions you take? And why? Do you know who their doctors are?

Probably not.

The **Have You Had the Talk** Toolkit helps you plan for a medical emergency now – while you are in control and can speak for yourself. Then, with your plan in place, you can go back to living the best possible life.

It's easy.

- **STEP 1: Clarify your thoughts and wishes.**
- **STEP 2: Organize paperwork and put wishes in writing.**
- **STEP 3: Have the Talk with the people you love.**
- **STEP 4: Be informed of services and resources available to help you and the people you love.**

Don't put the toolkit aside. Complete it, make copies of your completed documents and share them with the people you love. Keep the toolkit in the same place at all times. If it can't be found, it can't help.

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# TOOLKIT INTRODUCTION

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## Instructions for Completing Toolkit:

### STEP 1: Clarify your thoughts and wishes.

- The Six Questions Worksheet will get you thinking. Use the worksheet to jot down your wishes and hone in on what's most important.
- Think about who you'd want to carry out your instructions and make decisions on your behalf in the event of an emergency. The person you designate as your "health care agent" will be named on the California Advance Medical Directive in Step Two.
- Instructions for My Caregiver: Review the "Instructions," consider the choice you would make in the situations presented, then complete the instructions and sign and date the document.

### STEP 2: Organize paperwork and put wishes in writing.

- Once you've decided on the items in Step One, organize your medical and personal information and put your decisions in writing.

*(continued)*

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# TOOLKIT INTRODUCTION

## STEP 2: (continued)

- Complete the Medical and Personal Information Forms. This provides key information about your current health status in a format that will be easy to share with family, doctors and other emergency and health care personnel providing care and services to you. These forms also provide a place to record the location of key financial and supporting documents that will be helpful in an emergency.
- The California Advance Medical Directive provides the legal framework for designating a health care agent appointed by you to make decisions on your behalf in the event you can't speak for yourself. Talk to the person you want to designate to be your health care agent. Ask if he/she is willing to be appointed, explain why you have chosen this person and explain your wishes. Keep in mind that the person you choose may not feel comfortable with having the responsibility and you may need to ask someone else.
- Once you have completed the California Advance Medical Directive, ask two adults to witness as you sign the form. The witnesses must be 18 years of age or older and may include family and medical personnel where you receive care.

## STEP 3: Have the Talk with the people you love.

- Review the tips for talking with the people you love.
- Set up a time and place to have the talk.
- Tell the people you love about your wishes.
- Ask them about what they would want.
- Life and situations change. So, get a conversation going. Keep it going.

## STEP 4: Be informed

- Review the Internet Resources provided.
- Be resourceful in looking for articles, books and other sources of information about health care decision making and planning.

*(continued)*

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# TOOLKIT INTRODUCTION

## Other Instructions:

- Use the Check List to keep track. As you complete the forms in the toolkit, check off the item on the check list.
- Make copies of the documents and share them with your loved ones, attorney, and physicians.
- Place the completed documents in the enclosed GLAD bag and place in the freezer. Yes the freezer. If you keep the toolkit in the freezer, it is instantly accessible to anyone who needs it. No searching through files or a pile on your desk. If you decide to store the Toolkit in a more traditional location, be sure to mark that on the magnet and tell the people who need to know where to find it.
- Keep an extra set in the glove box of your car.
- Fill out the Have You Had the Talk Magnet with the location of your documents. Place on the freezer.
- Bring a copy of your Advance Medical Directive to the hospital each admission.
- Fill out the Wallet Card with emergency contact information and place in your wallet.
- Spread the word about the importance of Having the Talk. Be an advocate for making medical wishes known.

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# have you had the talk?™ GETTING STARTED

**The Check List will keep you on track.**

- ☐ Reviewed all documents in this toolkit.
- ☐ Made decisions about the care I want in the event of a medical emergency or event.
- ☐ Selected a health care advocate to make decisions on my behalf in the event I cannot make them for myself.
- ☐ Secured the permission of the person I selected to be my health care agent.
- ☐ Completed the Medical and Personal Information Forms in the toolkit.
- ☐ Completed the California Advance Medical Directive.
- ☐ Two adults have witnessed my signature to the California Advance Medical Directive (the witnesses must be 18 years of age or older and may include family and medical personnel where you receive care).
- ☐ Made copies of all documents and gave to the following people

  _____

  _____

- ☐ Put the documents in the provided GLAD bag and placed in orange folder and placed in freezer or other _____
- ☐ Put a copy in the glove box of my car.
- ☐ Completed the wallet card with emergency contact information.
- ☐ Completed the Refrigerator Magnet with Emergency Contact information and placed on Freezer.
- ☐ Set up a meeting with the important people in my life (including clergy) to Have the Talk.
- ☐ Had theTalk. Told the people I love about the kind of care I want if I am ever faced with a serious medical event.
- ☐ Talked to the people I love about what they want.

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# THE SIX QUESTIONS WORKSHEET

It's easy to talk about the weather, and the latest movie you saw. Harder to have a focused conversation about important topics and keep track of information.

The Six Questions Worksheet will get you started. The questions are provocative and are meant to help you clarify your wishes so you can make a plan and then live the best possible life.

☐ What tasks would you like to accomplish before you die?

_____

_____

☐ What does "quality of life" mean to you?

_____

_____

☐ What would a good death look like to you?

_____

_____

☐ What role would you like your loved ones to play in your dying?

_____

_____

☐ What kind of help and support would you like for you and your loved ones?

_____

_____

☐ Who would be the best person to advocate for you in an emergency?
*(Some traits your patient advocate needs: good organizational skills, good listening skills, ability to follow through, grasps details, cares about you and wants the best possible outcome, will follow your wishes and instructions.)*

_____

_____

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## TOPICS FOR DISCUSSION WITH YOUR FAMILY, HEALTH CARE AGENT & PHYSICIAN

The following checklist can be used to help you discuss how you would like to be treated in the event of a serious illness. Check the box next to each option that best describes your wishes and intentions.

First let's define our terms. Several references are made on this page to life-support treatment. Therefore it is important to define what the term means to you. Life support is usually defined as treatment that uses aggressive procedures (often including a medical device) to keep someone alive. These may include cardiopulmonary resuscitation (CPR), breathing tubes, tube feeding, dialysis, blood transfusions, surgery and antibiotics.

**In the event of serious illness:**
(Choose ***any or all*** of the following)

- ☐ I want my pain and symptoms managed so I am comfortable. I realize I might become drowsy and sleep more as a result.
- ☐ I want to have food and fluids (by mouth).
- ☐ I do not want any medical procedures that have the intention of hastening my death.
- ☐ I would like to be kept clean and warm.

**In the event of severe brain damage with no expectation of recovery:**

If I suffer severe brain damage and the medical professionals overseeing my care conclude it is permanent and irreversible AND life-sustaining measures would only delay my death: (Choose ***one***)

- ☐ I wish to have life-support treatment.
- ☐ I do not want life-support. If treatment has begun,
  - ☐ I want it stopped.
- ☐ I want life-support measures if my physician believes such treatment could improve my condition. If life-support measures are not proving to be beneficial, I want them stopped.

**In the event of irreversible coma:**

If I am in a coma and the medical professionals overseeing my care agree I will not wake up or recover AND I have brain damage AND life-support would only delay my death: (Choose ***one*** of the following)

- ☐ I wish to have life-support treatment.
- ☐ I do not want life-support. If treatment has begun,
  - ☐ I want it stopped.
- ☐ I want life-support measures if my physician believes such treatment could improve my condition. If life-support measures are not proving to be beneficial, I want them stopped.

**When I am close to death:**

If the medical professionals overseeing my care agree that I am likely to die in a short period of time and life-sustaining measures would only delay my death: (Choose ***one*** of the following.)

- ☐ I wish to have life-support treatment.
- ☐ I do not want life-support. If treatment has begun,
  - ☐ I want it stopped.
- ☐ I want life-support measures if my physician believes such treatment could improve my condition. If life-support measures are not proving to be beneficial, I want them stopped.

**Life-support treatments**

The following limits define which life-sustaining measures I **do** or **do not** wish to have, and under what conditions:

_____

_____

_____

*Please note that this form is not your California Advance Medical Directive – it is a tool to help you consider what you want to include in your advance directive.*

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# MEDICAL INFORMATION

**My name:** Date:

Birthdate: Bloodtype:

Allergies:

**In case of emergency contact:**

Name:

Relationship to me:

Cell: Home: Work:

Name:

Relationship to me:

Cell: Home: Work:

Name:

Relationship to me:

Cell: Home: Work:

*If I am unable to make decisions on my own behalf,*

**I have designated the following person to make them for me:**

Name:

Street Address:

City: State: Zip:

Cell: Home: Work:

**My California Advance Medical Directive can be found:**

Last updated:

Last witnessed:

**My Last Will and Testament can be found:**

Last updated:

Last witnessed:

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## MEDICAL INFORMATION *continued*

**Other important documents can be found:**

### Diagnoses

| Diagnosis | Date | Physician | Treatment |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

### Surgeries/Medical Procedures

| Surgery | Date | Surgeon | Hospital |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

### Current Medications

| Prescription | Date | mg | Frequency / Instructions | Treats (name condition) |
|---|---|---|---|---|
| | | | | |
| | | | | |
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## MEDICAL INFORMATION *continued*

### Primary Physician

Name:

Street Address:

City: State: Zip:

Phone:

Directions:

### Specialist Physician

Name:

Street Address:

City: State: Zip:

Phone:

Directions:

### Specialist Physician

Name:

Street Address:

City: State: Zip:

Phone:

Directions:

### Other Medical Professional

Name:

Street Address:

City: State: Zip:

Phone:

Directions:

### Other Medical Professional

Name:

Street Address:

City: State: Zip:

Phone:

Directions:

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## MEDICAL INFORMATION *continued*

### Other Important Contact

Name:

Street Address:

City: State: Zip:

Phone:

Directions:

### Other Important Contact

Name:

Street Address:

City: State: Zip:

Phone:

Directions:

### Other Important Contact

Name:

Street Address:

City: State: Zip:

Phone:

Directions:

### Other Important Information

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# TIPS FOR HAVING THE TALK

"Having the Talk" is simply about preparing in advance to deal with a medical event – even a routine one. Sharing your plans will give your loved ones confidence to assist you with a health related matter. Once you "have the talk," your loved ones will have all the information they need: your health status, your doctors, prescriptions, your wishes, and their role in assisting you.

"Having the Talk" is a practical step to take and it provides you and your loved ones with an opportunity to have a meaningful conversation about some of the big issues in life. Once you get this conversation going, you may be surprised at how helpful and enriching it is, and you might be surprised by what people say!

## HERE ARE SOME TIPS:

- Let your loved ones know you want to meet and share the plans you have made in the event of a routine medical procedure or other health-related event.
- Set a time and place and have a set plan for the information you want to share. (If it's hard to find a time when everyone can meet, choose a time when you already know you'll be together – like Thanksgiving or other holiday.)
- Select a location where you can talk comfortably.
- Have a specific timeframe for going through your plan and sharing your wishes. Two hours allows plenty of time to share the information and have a lively conversation about what you and your loved ones would want when faced with a medical situation.
- Getting together for "the talk" can and should be a meaningful event. Have refreshments and encourage everyone to be comfortable.
- Make copies of all of your documents so they can be shared.
- Expect that there will be distractions and that the subject will be changed as the conversation gets going.
- Be prepared to bring the conversation back on track so that you accomplish the goals for the meeting.

(continued)

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# TIPS FOR HAVING THE TALK *continued*

## TOPICS TO CONSIDER:

- Where to find medical information about you. Show them the toolkit. Show them the forms you completed. Now easy to find, they will know all of your doctors, prescriptions and diagnoses. Tell them where you will be keeping it.
- Current health status. Even if you are in perfect health, let them know. It is not uncommon to be presented with a routine procedure. If you go to the hospital, your family will have all the information they need to assist you. If you've been ill or had surgeries, give them an overview of what issues you have had to manage. Don't get bogged down in details at this point.
- Let them know who you have selected to be your "Health Care Agent." (Make sure this person already has agreed to be your advocate and understands their role.)
- Tell them some of the situations you have considered and the kind of care you would want. These decisions are not set in stone. They can be changed at any time. The idea is to get family members to understand your basic philosophy about these matters so that they know what you'd want and can help ensure you get the care you'd want.
- Ask them if they have thought about the care they would want. Get them talking about their wishes and encourage them to follow a process to select a "patient advocate" and complete a process like the one you have.
- Ask them if they have questions.
- If there are conflicts in the family, this is an especially good time to talk about your wishes. Conflicts can be prevented during health care events by getting all parties on the same page. This way its clear that plans have been made by you and for you.

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# INTERNET RESOURCES

This list of nonprofit resources was compiled to help you make informed choices about end- of-life issues. Information is available from these organizations at no cost to you. Generally speaking, if it isn't free, or they ask for anything besides your address... you don't want it!

**American Hospital Association** www.putitinwrting.org

Key resources to enhance educational efforts and raise awareness about advance directives. Compiled by the American Hospital Association with the cooperation of other organizations.

**Caring Connections** www.caringinfo.org

State-specific advance directives with instructions are available for free download after registration of name and email address. Caring Connections empowers consumers to take action; specifically the campaign encourages people to: learn about your options for end-of-life services and care; implement plans to ensure your wishes are honored; and voice your decisions to family, friends and health care providers.

**Caring Conversations** www.practicalbioethics.org/cpb.aspx?pgID=886

The Caring Conversations workbook provides a social ritual that helps loved ones plan for the end of life. Sharing the information in Caring Conversations allows others to understand and respect the preferences of patients who can no longer speak for themselves and eases the tension that patients and their families experience during a last illness. The workbook (also available in Spanish) is intended to help you, your family, and your friends think about these issues now, while you are able to respond to specific questions.

**Compassion & Choices** www.compassionandchoices.org

Compassion & Choices is a nonprofit organization working to improve care and expand choice at the end of life. As a national organization with over 60 chapters and 30,000 members, Compassion & Choices helps patients and their loved ones face the end of life with facts and choices of action during a difficult time. They aggressively pursue legal reform to promote pain care, put teeth in advance directives and legalize physician aid in dying.

**National Hospice and Palliative Care Organization** www.nhpco.org

Hospice and palliative care involve a team-oriented approach to expert medical care, pain management, and emotional and spiritual support expressly tailored to the patient's needs and wishes. Support is provided to the patient's loved ones as well. At the center of hospice and palliative care is the belief that each of us has the right to die pain-free and with dignity, and that our families will receive the necessary support to allow us to do so. Website provides articles and additional links to resource information.

**On Our Own Terms – Bill Moyers** www.pbs.org/wnet/onourownterms

There is a great divide separating the kind of care Americans say they want at the end of life and what our culture currently provides. Surveys show that we want to die at home, free of pain, surrounded by the people we love. But the vast majority of us die in the hospital, alone, and experiencing unnecessary discomfort. Bill Moyers goes from the bedsides of the dying to the front lines of a movement to improve end-of-life care in ON OUR OWN TERMS: Moyers on Dying.

# STEP BY STEP GUIDE TO COMPLETING THE CALIFORNIA ADVANCE MEDICAL DIRECTIVES

## Introduction

An advance directive is a document that any adult may complete in order to communicate his/her wishes regarding health care. This document goes into effect when the person who completed it becomes unable to make his/her own decisions. Each state has a version of this type of document, and states generally do recognize forms from other localities. In California, the form is broken down into five parts. Although it is recommended that you complete all five parts, an advance directive is still valid if only some parts are completed.You do not need an attorney to complete the form. All that is required is the signature of two witnesses. Once completed, it is best to give a copy to your primary care physician and keep an additional copy in a location where you and your loved ones will know where to find it. Even though the form changed in 2009, old forms are still valid. However, the new forms allow you to include some powers that are not included in the old forms. If you want to give those new powers to your loved ones, you must complete a new form.

## Section One: Appointment of Agent

Section 1 of this form lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions, or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you.

Your agent may not be an operator or employee of a community care facility or a residential care facility where you are receiving care, or your supervising health care provider or an employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.

Unless you state otherwise in this form, your agent will have the right to:

1. Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.
2. Select or discharge health care providers and institutions.
3. Approve or disapprove diagnostic tests, surgical procedures, and programs of medication.
4. Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.
5. Donate organs or tissues, authorize an autopsy, and direct disposition of remains.

*(continued)*

## Section One: Appointment of Agent (continued)

However, your agent will not be able to commit you to a mental health facility, or consent to convulsive treatment, psychosurgery, sterilization or abortion for you.

## Section Two: Instructions for Health Care

Section 2 of this form lets you give specific instructions about any aspect of your health care, whether or not you appoint an agent. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, as well as the provision of pain relief. You also can add to the choices you have made or write down any additional wishes. If you are satisfied to allow your agent to determine what is best for you in making end of life decisions, you need not fill out section 2 of this form.

Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health care directive or replace this form at any time.

## Section Three: Donation of Organs at Death

This is your chance to become an organ donor or to donate your body to medicine, upon your death. Like your driver's license, this section constitutes legally binding consent. To become an organ donor, write down the name of the individual who is instructed to sign the consent forms after you die, or check the box to include this with the powers of the Agent that you identified in Section One of the Advance Directive.

Be certain to provide any special instructions that you might have in the space provided. If you do not want to donate certain organs, make that clear. If you want something other than organ donation to be done with your body, make that clear. Be aware, however, that "donating your body to science" is not simple. If you want your body to be used for any specific research purpose or to go to any particular medical school, you will have to make arrangements in advance. Once you have done so, make note of that fact in the space provided. If you leave no special note, it will be assumed that you consented to having all of your useful organs and tissue made available for transplant.

## Section Four: Physician Designation

This part of the form lets you designate a physician to have primary responsibility for your health care.

## Section Five: Witnesses and Storage

Your advance directive must be signed by two adult witnesses. Any two adults, including family members, can be witnesses to your document. These people are not taking any responsibility for your care or for the cost of your care. They are not verifying any of the things that you put in your advance directive. These witnesses are only witnessing your signature, and saying that you are the person who completed the form. You do not need a lawyer or a notary public to complete this form.

Once you have completed your advance directive, you should store it in a place where your loved ones can easily find it when they need it. Do not put it in a safety deposit box. It is better to keep it at home in a file cabinet, drawer or in a storage bag in the freezer. It is important to tell your loved ones where you have put it. You can also make copies of the document and give one to your doctor, the hospital, and a copy can stay in the glove box in your car. Bring a copy with you to the hospital each admission. The important thing is that people know that you have an advance directive and that they can find it when they need it.

# CALIFORNIA ADVANCE MEDICAL DIRECTIVE

I, _____, intentionally and voluntarily make known my wishes in the event that I am incapable of making an informed decision, as follows:

I understand that my advance directive may include the selection of an agent in addition to setting forth my choices regarding health care. The term ***"health care"*** means: the furnishing of services to any individual for the purpose of preventing, alleviating, curing or healing human illness, injury or physical disability, including but not limited to medications; surgery; blood transfusions; chemotherapy; radiation therapy; admission to a hospital, nursing home, assisted living facility or other health care facility; psychiatric or other mental health treatment; and life-prolonging procedures and palliative care.

The phrase ***"incapable of making an informed decision"*** means: unable to understand the nature, extent and probable consequences of a proposed health care decision; unable to make a rational evaluation of the risks and benefits of a proposed health care decision as compared with the risks and benefits of alternatives to that decision; or unable to communicate such understanding in any way.

This advance directive shall not terminate in the event of my disability.

(YOU MAY INCLUDE IN THIS ADVANCE DIRECTIVE ANY OR ALL OF SECTIONS I THROUGH V BELOW.)

## SECTION I: APPOINTMENT OF AGENT

*(CROSS THROUGH SECTION I AND SECTION II BELOW IF YOU DO NOT WANT TO APPOINT AN AGENT TO MAKE HEALTH CARE DECISIONS FOR YOU.)*

I hereby appoint the following as my primary agent to make health care decisions on my behalf as authorized in this document:

Name of Primary Agent:

Street Address:

City: State: Zip:

Phone: Fax (if any):

Email (if any):

If the above-named primary agent is not reasonably available or is unable or unwilling to act as my agent, then I appoint the following as successor agent:

Name of Successor Agent:

Street Address:

City: State: Zip:

Phone: Fax (if any):

Email (if any):

I hereby grant to my agent named above full power and authority to make health care decisions on my behalf as described below whenever I have been determined to be incapable of making an informed decision. My agent's authority is effective as long as I am incapable of making an informed decision.

In exercising the power to make health care decisions on my behalf, my agent shall follow my desires and preferences as stated in this document or as otherwise known to my agent. My agent shall be guided by my medical diagnosis and prognosis and any information provided by my physicians as to the intrusiveness, pain, risks and side effects associated with treatment or nontreatment.

My agent shall not make any decision regarding my health care which he or she knows, or upon reasonable inquiry ought to know, is contrary to my religious beliefs or my basic values, whether expressed orally or in writing. If my agent cannot determine what health care choice I would have made on my own behalf, then my agent shall make a choice for me based upon what he or she believes to be in my best interests.

My agent shall not be liable for the costs of health care that he or she authorizes, based solely on that authorization.

## SECTION II: INSTRUCTIONS FOR HEALTH CARE

If you fill out this part of the form, you may strike any wording you do not want.

**END OF LIFE DECISIONS:**
I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

**Choice Not To Prolong Life:**

_____ *(Initial here)*

I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits,

**OR**

**Choice To Prolong Life:**

_____ *(Initial here)*

I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

**RELIEF FROM PAIN:**
Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death: *(Add additional sheets if needed.)*

_____

_____

*(continued)*

## SECTION II: INSTRUCTIONS FOR HEALTH CARE (Continued)

**OTHER WISHES:**

(If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

*(Add additional sheets if needed.)*

_____

_____

_____

## SECTION III: DONATION OF ORGANS AT DEATH

**1. Upon my death:**

I give any needed organs, tissues, or parts _____
*(Initial here)*

**OR:**

I give the following organs, tissues, or parts only:_____

_____ _____
*(Initial here)*

If you wish to donate organs, tissues, or parts, you must complete 2. and 3.

**2. My gift is for the following purposes:**

Transplant _____
*(Initial here)*

Research _____
*(Initial here)*

Therapy _____
*(Initial here)*

Education _____
*(Initial here)*

*(continued)*

## SECTION III: DONATION OF ORGANS AT DEATH

**3. I understand that tissue banks work with both nonprofit and for-profit tissue processors and distributors. It is possible that donated skin may be used for cosmetic or reconstructive surgery purposes. It is possible that donated tissue may be used for transplants outside of the United States.**

A. My donated skin may be used for cosmetic surgery purposes.

Yes _____ *(Initial here)* No _____ *(Initial here)*

B. My donated tissue may be used for applications outside the United States.

Yes _____ *(Initial here)* No _____ *(Initial here)*

C. My donated tissue may be used by for-profit tissue processors and distributors.

Yes _____ *(Initial here)* No _____ *(Initial here)*

**AGENT'S POSTDEATH AUTHORITY:** My agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains, except as I state here or in Part 3 of this form:

_____

_____

## SECTION IV: PRIMARY PHYSICIAN

I designate the following physician as my primary physician:

Name of Physician:

Street Address:

City: State: Zip:

Phone:

OPTIONAL: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

Name of Physician:

Street Address:

City: State: Zip:

Phone:

## SECTION V: SIGNATURE

The form must be signed by you and by two qualified witnesses, or acknowledged before a notary public.

**SIGNATURE:**

Sign and date the form here

Date:_____ Time: _____ AM / PM

Signature (patient): _____

Print name (patient): _____

Address: _____

**STATEMENT OF WITNESSES:**

I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence, (2) that the individual signed or acknowledged this advance directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

**FIRST WITNESS**

Name: :_____ Telephone: :_____

Address: _____

Date:_____ Time: _____ AM / PM

Signature (witness): _____

Print name (witness): _____

*(continued)*

## SECTION V: SIGNATURE CONTINUED

### SECOND WITNESS

Name: :_____ Telephone: :_____

Address: _____

Date:_____ Time: _____ AM / PM

Signature (witness): _____

Print name (witness): _____

### ADDITIONAL STATEMENT OF WITNESSES:

At least one of the above witnesses must also sign the following declaration:

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance health care directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law.

Date:_____ Time: _____ AM / PM

Signature (witness): _____

Print name (witness): _____

YOU MAY USE THIS CERTIFICATE OF ACKNOWLEDGMENT BEFORE A NOTARY PUBLIC INSTEAD OF THE STATEMENT OF WITNESSES.

State of California, County of _____

On *(date)* _____ before me, *(name and title of the officer)* _____ _____ personally appeared *(name(s) of signer(s))* _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal. [Civil Code Section 1189]

Signature (notary): _____ [Seal]

*(continued)*

## SECTION V: SIGNATURE CONTINUED

### SPECIAL WITNESS REQUIREMENT

If you are a patient in a skilled nursing facility, the patient advocate or ombudsman must sign the following statement:

STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN

I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section 4675 of the Probate Code.

Date:_____ Time: _____ AM / PM

Signature (patient advocate or ombudsman): _____

Print name (patient advocate or ombudsman): _____

Address: _____

# ABOUT HOFFMANN HOSPICE A FULL-SERVICE, NONPROFIT HOSPICE

Hoffmann Hospice is a full service non-profit hospice committed to going above and beyond in meeting the needs of our patients and families. Our mission is to celebrate the sanctity of life, provide compassionate end of life care, and comfort the grieving. We provide medical, nursing, spiritual, and psychosocial support to patients and families needing end of life care. Hospice is a philosophy of care committed to helping a person live out their final season of life as fully as possible regardless of age, race, culture or diagnosis. Research shows that people who use hospice services live longer and have significantly better quality of life than those who do not elect to use hospice services. At Hoffmann Hospice, hospice care is what we do. We are experts at caring for people during this challenging stage of life.

## Levels of Care

We provide four levels of care through the Medicare hospice benefit, Medi-Cal hospice benefit and most commercial insurances.

- Routine hospice care in the home or other residential facility, such as an assisted living or nursing facility
- Respite care – patient care is provided in area nursing facilities or hospitals for up to five days in order to provide relief for the patient's caregivers.
- Inpatient care – inpatient hospice care is available in the acute hospital of choice for patients whose symptoms cannot be adequately managed at home.
- Continuous care – for challenging time or times of crisis when extra medical attention is required.