



STANFORD
HOSPITAL & CLINICS

Stanford University Medical Center



Your Right to Make Health Care Decisions



Advance Care Planning

Stanford Hospital & Clinics is committed to helping you exercise your rights in relation to your medical treatment. We hope this information will help increase your control over your medical treatment.

What is Advance Care Planning?

Advance Care Planning is a patient-centered process of communication with patients and their families about their wishes/treatment preferences so that their goals of health care are honored and implemented. Advance Care Planning is not limited to a single event or a single conversation. It is often accomplished through a series of discussions and health care encounters.

What is an Advance Health Care Directive?

An Advance Health Care Directive is a document that enables you to: 1) state your health care instructions for any situation; and 2) designate another person to make health care decisions on your behalf should you be unable to do so. It's called "advance" because you prepare it before health care decisions need to be made. It's called a "directive" because it states who will speak on your behalf and what you would want done. In California, the Advance Health Care Directive includes the appointment of an agent and your Health Care instructions.



Who makes decisions about my medical treatment?

You have the right to decide. Your physicians will give you information and their recommendations concerning your treatment. You can say "yes" to the recommended treatments or procedures you want. You can say "no" to any treatment or procedure you do not want, even when it's a treatment or procedure which might help you to live longer.

How do I know what I want?

Your physician will tell you about your medical condition. Your physician will also tell you about any treatments, procedures or pain management options recommended for your condition, along with any possible side effects. Your physician must offer you information about any possible side effects of the different treatments or procedures.

More than one treatment option is often available to help patients. Your physician can tell you which treatments are available to you, but the physician cannot choose for you. That choice is yours to make and will depend upon what's important to you.



When is a good time to prepare an Advance Directive for health care?

Any time is a good time. The ideal time might be when you are well and have the time to think about what you might want or not want should you have a terminal condition. It's also important to have a conversation with the persons you name as your agents so they know what you'd want.

Can other people help with my decisions?

Yes. Patients often turn to their relatives and close friends for help in making medical decisions. Your family or friends can help you think about the choices you face and how you might want to make your decisions based on your values and wishes.

May I choose a relative or friend to make health care decisions for me?

Yes, you may choose to have a relative or friend make health care decisions for you. There are several ways you can do that:

- You can tell your physician to list that person as your health care "surrogate" in your medical record for this hospitalization.
- You can name this person as your "agent" on the "Advance Health Care Directive Information" sheet (Form 15-1811) which will be valid for a particular hospitalization or 60 days, whichever comes first.
- You can name this person as your "agent" in an Advance Health Care Directive.

What if I become too sick to make my own health care decisions?

If you have named an agent, the physicians will ask that person to make decisions for you. If you haven't named an agent, your physician will ask your closest available relative or friend to help decide what is best for you. Most of the time that works, but sometimes family members or friends don't agree about what to do or don't know what you would want. That's why it is helpful for you to designate an agent who knows what you would want if you cannot speak for yourself.





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Who can make an Advance Health Care Directive?

If you are 18 years or older and of “sound mind,” you can make an Advance Health Care Directive. You do not need a lawyer and you do not need a notary. You can complete the form in this booklet and ask two people to witness your signature. Neither of these people can be one of your designated health care agents. At least one of the witnesses cannot be related to you by blood, marriage, or adoption and cannot be entitled to any part of your estate upon your death.

Who can I name as my agent?

You can choose an adult relative or any other person you trust to speak for you when medical decisions must be made. It is recommended that you have a conversation with this person about your values and wishes so that she or he will really know what you would want. The following persons may not be your agent: your supervising health care provider, an employee of the health facility where you are receiving care, or an employee or operator of community care and residential care facilities where you are receiving care.

When does my agent begin making my medical decisions?

Usually your health care agent will make decisions only if you lose the ability to make them yourself. If you wish, you can state in your Advance Health Care Directive that you want your agent to begin making decisions immediately.

What if I don't want to name an agent?

You do not have to designate an agent. You can still write out your wishes in an Advance Health Care Directive. This will give your physicians and your family or friends some idea of what you would want if the time came that you couldn't speak for yourself. You can also discuss your wishes with your doctor and ask your doctor to list those wishes in your medical record.



Will I still be treated if I don't make an Advance Health Care Directive?

Absolutely. You will still get medical treatment. If you become too sick to make decisions yourself, someone else will have to make them for you.



What happens when someone else makes decisions about my treatment?

The same rules apply to anyone who makes health care decisions on your behalf – a health care agent, a surrogate whose name you gave to your doctor, or a person appointed by a court to make decisions for you. All are required to follow your health care instructions in your Advance Health Care Directive. If you have not written anything down, they are required to follow your general wishes about treatment. If your treatment wishes are not known, the agent must try to determine what is in your best interest.

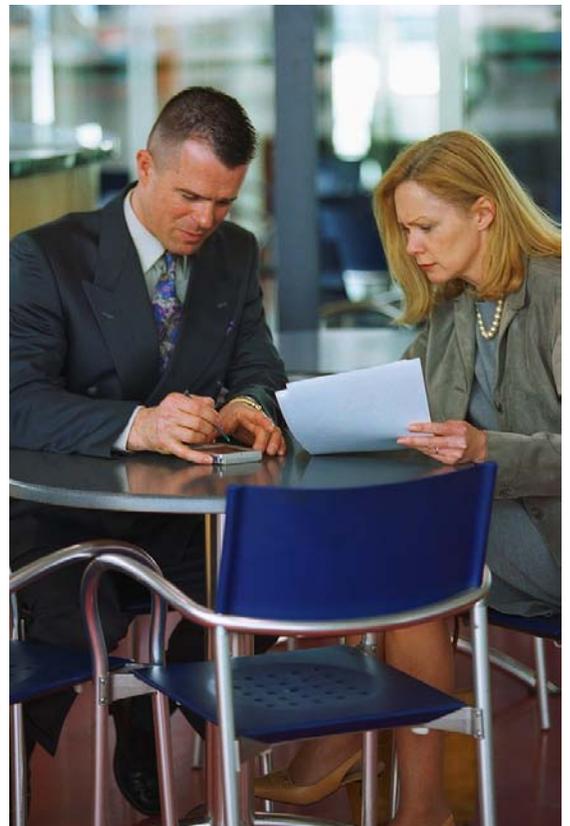
The people providing your health care must follow the decisions of your agent unless a requested treatment is not within recognized medical standards or would be ineffective in your situation. If this causes disagreement that cannot be worked out, the provider must make a reasonable effort to find another health care provider to take over your treatment.

What if I change my mind?

You can change or cancel your Advance Health Care Directive at any time as long as you can communicate your wishes. To change the name of your agent, you must complete a new Advance Health Care Directive, sign a new Advance Health Care Directive information sheet, or tell the doctor in charge of your care. When you prepare a new Advance Health Care Directive, give or send a copy of the new document to your physicians and agents. You can bring a copy with you to your next appointment. If your document is prepared at Stanford, the staff who assist you will make the necessary copies including a copy for your electronic medical record.

What should I do after I have my Advance Health Care Directive signed and witnessed?

If you prepare the document at home, make photocopies of the form for your agent, alternate agents, anyone else of your family or friends who might be involved in your care. Bring a photocopy to your doctor at your next visit so it can be included in your medical record. Make some extra copies so you can take one with you if you are admitted to a hospital, skilled nursing facility or any other health care facility. Keep the original in a place where you can access it easily and you can tell others how to find it as well.



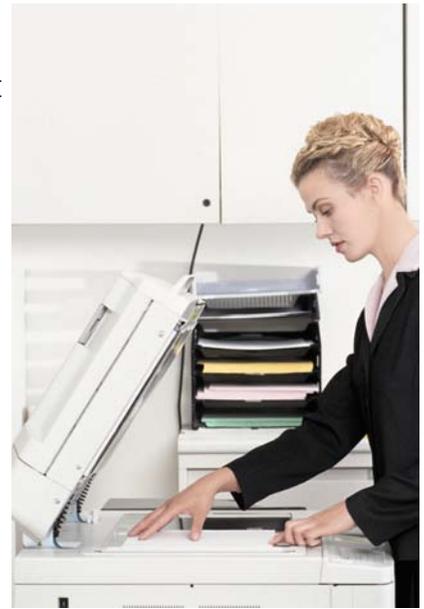
If you prepare the document while at Stanford Hospital, the staff who assist you will make the needed photocopies and will make sure a copy is sent to Medical Records for your electronic medical record.

You may also register your Advance Health Care Directive with the California registry. Please refer to the following site for information:

<http://www.sos.ca.gov/ahcdr/>

How can I get more information about making an Advance Health Care Directive?

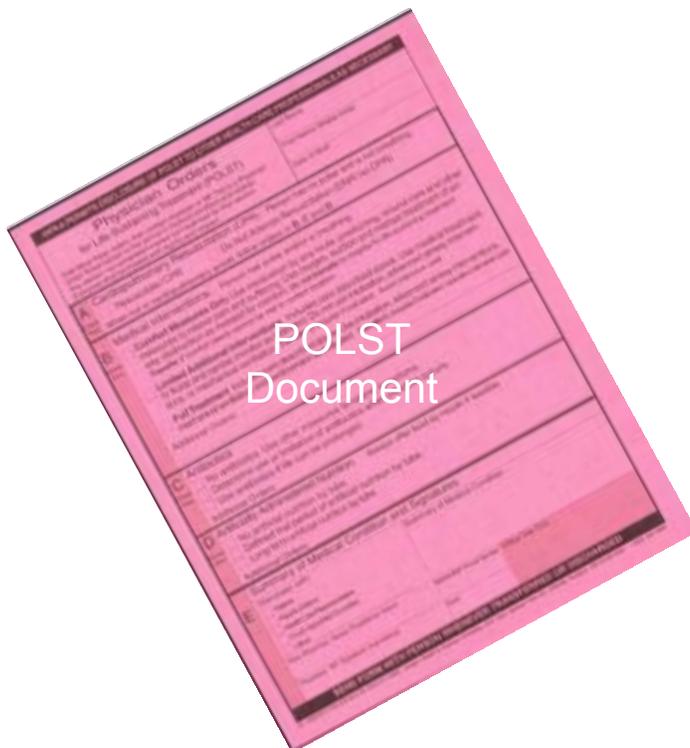
When you are admitted, you will be asked if you have an Advance Health Care Directive. If you don't have one, you will be asked if you want to create one. You can also ask your doctor, nurse, social worker, or other health care provider to get more information for you. You can have a lawyer write an Advance Health Care Directive for you or you can complete an Advance Health Care Directive form. Call the Spiritual Care Service to obtain additional copies of this form (3-5101 from phones in the hospital or 650-723-5101 from phones outside the hospital).



Are there other ways that I can make my health care wishes known?

For persons with a life-limiting illness, a POLST (Physician Orders for Life-Sustaining Treatment) is a document designed to express a preference for levels of treatment. It includes orders describing CPR, Medical Interventions (intensity of care—ICU, no-ICU, comfort care, etc.) and the use of artificial nutrition. This document is intended to stay with a patient whether an in-patient or an out-patient. It is signed by the patient or the patient's legally recognized decision maker. It is also signed by the patient's physician. It does not replace the Advance Health Care Directive .

Information about the POLST is also available at: <http://www.capolst.org> where you can also download a copy of the form. Copies of this form are also available should you need one from Spiritual Care staff, Palliative Care staff and Guest Services staff.





Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

Please print clearly:

Patient Name _____

Patient MRN _____ Patient DOB _____

PART 1—POWER OF ATTORNEY FOR HEALTH CARE

Part 1 allows you to 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 these decisions for you now, even though you are still capable. You may also name alternate agents to act for you if your first agent is unwilling, unable, or reasonably unavailable to make decisions for you. (Your agent may not be your supervising health care provider or an employee of the health care institution where you are receiving care, unless this person is related to you or is a coworker.) You should talk with the person(s) you have named as your agent to make sure they understand your wishes and are willing to take responsibility.

- I do not wish to appoint an agent. (if you check this box, go to PART 2 on page 3.)
- I wish to appoint an agent.

I designate the following individual as my agent to make health care decisions for me:

(Name of individual you choose as agent)

(address) (city) (state) (zip code)

Home: _____ Cell: _____ Work: _____
(telephone numbers with area code)

OPTIONAL: 1st alternate agent

(Name of individual you choose as agent)

(address) (city) (state) (zip code)

Home: _____ Cell: _____ Work: _____
(telephone numbers with area code)

(Continued on page 2)

Medical Record Number

Patient Name



Addressograph or Label - Patient Name, Medical Record Number

(Continued from page 1)

OPTIONAL: 2nd alternate agent

(Name of individual you choose as agent)

(address) (city) (state) (zip code)

Home: _____ Cell: _____ Work: _____
(telephone numbers with area code)

1.2 Agent's Authority—My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care, **except** as I state here:

(Add additional sheets if needed.)

1.3 When Agent's Authority Becomes Effective: My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions.

Optional: I want my agent to begin to make health care decisions for me now, **even though I am still able to make them for myself.** I understand and authorize this statement as proved by my signature here:

1.4 Agent's Obligation: My agent shall make health care decisions for me in accordance with this Advance Health Care Directive, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

1.5 Who May NOT Make My Medical Decisions

The following person(s) are to be EXCLUDED from health care decision-making for me: _____ (initial here) _____

Or
 No Exclusions (initial here) _____

1.6 Agent's Post-Death Authority: My agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains, except as I state here, in Part 3 of this form, or as I have stated in a contract with a funeral home, in my will, through Donate Life California Organ and Tissue Registry or by some other written method.

(Continued on page 3)



Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

(Continued from page 2)

(Add additional sheets if needed.)

1.7 Nomination of Conservator: If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is unwilling, unable, or reasonably unavailable to act as conservator, I nominate the alternate agents whom I have named, in the order designated.

PART 2—Instructions for Health Care

Part 2 lets you give specific instructions about any aspect of your health care, regardless of whether or not you appoint an agent. You can express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, as well as the provision of pain relief by selecting one of the two options listed below. Space is also provided for you to add to the options you have selected or for you to write out 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 this part.

OPTIONAL: If I am suffering from a terminal condition from which death is expected in a matter of months, or if I am suffering from an irreversible condition that renders me unable to make decisions for myself, and life-support or life-sustaining treatments are needed to keep me alive, then:

I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and that my physicians allow me to die as gently as possible. I understand and authorize this statement as proved by my signature here:

OR

I want my life to be prolonged as long as possible within the limits of generally accepted health care standards. I understand and authorize this statement as proved by my signature here:

If you wish to modify or add to either statement above or to write your own statement instead, you may do so in the space provided or on separate sheets of paper. You must date, sign and attach to this directive any separate sheets.

OPTIONAL: Other or additional statements of medical treatment desires and limitations:

(Continued on page 4)

Medical Record Number

Patient Name



Addressograph or Label - Patient Name, Medical Record Number

(Continued from page 3)

OPTIONAL: I have added _____ page(s) of specific health care instructions to this Directive, each of which is signed and dated on the same day I signed this Directive.

OPTIONAL: I have a fully executed POLST (Physician Orders for Life-Sustaining Treatment) dated _____ that identifies my specific health care wishes as indicated by my initials

here: _____

Keep a copy of any POLST form with you at all times.

PART 3—OPTIONAL—Donation of Organs at Death

Part 3 lets you express an intention to donate your bodily organs and tissues following your death.

I have previously registered my decision to be a donor with “Donate Life California Organ and Tissue Donor Registry” through

- my driver’s license and/or
- signed up online at www.donateLIFCalifornia.org.

I wish to be an organ and/or tissue donor. I understand and authorize this statement as proved by my signature here:

PART 4—OPTIONAL—Designation of Primary Physician

Part 4 lets you designate a physician to have primary responsibility for your health care..

I designate the following physician as my primary physician:

Name of Physician _____

Address _____

City _____ State _____ Zip Code _____

Phone(s) including area code _____

(Continued on page 5)



Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

(Continued from page 4)

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 _____

Address _____

City _____ State _____ Zip Code _____

Phone(s) including area code _____

PART 5

After completing the above sections, please sign and date the form here. The form must also be signed by two qualified witnesses or acknowledged before a notary public. If you are unable to sign, but ARE able to communicate your wishes for this document, an adult may sign your name in your presence and at your direction.

I revoke any prior Power of Attorney for Health Care or Natural Death Act Declaration. My agent and others may use copies of this document as though they were originals.

Signature: Sign and date the form here:

Sign your name _____ Date _____

Print your name _____

Address _____

City _____ State _____ Zip Code _____

OPTIONAL: Name and signature of adult signing Principal's name in Principal's presence and at Principal's direction:

Print Name Date Signature

(Continued on page 6)

Medical Record Number

Patient Name



Addressograph or Label - Patient Name, Medical Record Number

(Continued from page 6)

Statement of Witnesses: I declare under penalty of perjury under the laws of the State 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 Health Care 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 Health Care 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 (print name) _____

Address _____

City _____ State _____ Zip Code _____

Signature _____ Date _____

Second Witness (print name) _____

Address _____

City _____ State _____ Zip Code _____

Signature _____ Date _____

(Continued on page 7)



Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

(Continued from page 6)

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 the State 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.

Signature of Witness _____

EVIDENCE OF IDENTITY: The following forms of identification are satisfactory evidence of identity: an inpatient wristband, a California driver's license or identification card or U.S. Passport that is current or issued within five years, or any of the following if the document is current or has been issued within 5 years, contains a photograph and description of the person named on it, is signed by the person, and bears a serial or other identifying number:

- A foreign passport that has been stamped by the U.S. Immigration and Naturalization Service
- A driver's license issued by another state or by an authorized Canadian or Mexican agency
- An identification card issued by another state or by any branch of the U.S. armed forces
- For an inmate in custody, an inmate identification card issued by the Department of Corrections.

PART 6 Skilled Nursing Facility—Special Witness Requirement

The following statement is required only if you are a patient in a skilled nursing facility—a health care facility that provides the following basic services: skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. The patient advocate or ombudsman must sign the following statement. *(An ombudsman is a volunteer who assists residents of long-term care facilities in the assertion of their civil and human rights.)*

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

Name _____ Title _____

Address _____

Signature _____ Date _____

State of California)

County of _____)

(Continued on page 8)

Medical Record Number

Patient Name

STANFORD HOSPITAL and CLINICS
STANFORD, CALIFORNIA 94305



Addressograph or Label - Patient Name, Medical Record Number

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ADVANCE HEALTH CARE DIRECTIVE Page 8 of 8

PART 7—OPTIONAL—Certificate of Acknowledgment of Notary Public

Signing before a notary public is not required if qualified witnesses have signed on page 7. If you are a resident of a skilled nursing facility, you must have the patient advocate or ombudsman sign the statement of witnesses on page 7 and the statement above, even if you choose to have this form notarized.

On _____ before me, _____ (*insert name and title of officer*), personally appeared _____ (*insert name of principal*) 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.

Signature _____ (Seal)



Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

**CORE DATA
ADVANCE HEALTH CARE DIRECTIVE**

PART 8—Health Care Instructions

Optional: Other or additional statements of medical treatment desires and limitations.

Attachment _____ of _____

Signature _____ Date _____



STANFORD

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We take all feedback very seriously. Please direct your comments to Guest Services at 650-498-3333. For quality of care concerns, you may also contact the Joint Commission at 800-994-6610 or send an email to complaints@jointcommission.org.

If you have any feedback specifically about the hospital's provision of information on Advance Health Care Directives, you may contact:

Department of Health Services
Licensing and Certification Division
100 Paseo de San Antonio, Suite 235
San Jose, CA 95113
408-277-1784
FAX 408-277-1032

If you are a Medicare patient with any feedback about the hospital's provision of information on Advance Health Care Directives, you may also call the Medicare Hotline: 1-800-MEDICARE or 1-800-633-4227.

PHONE NUMBERS

Guest Services650-498-3333
Ethics Committee650-723-5760
Interpreter Services650-723-6940
Medical Records650-723-5721
Palliative Care 650-723-3736, pager 26254
Patient Access Services650-723-6221
Social Services650-723-5091
Spiritual Care Service 650-723-5101, pager 15683
The Health Library650-723-8400