WHY DO I NEED AN ADVANCE DIRECTIVE?

Medical technology has given us many new options for sustaining life. This makes it important for you to discuss what kind of care you want before serious illness or accident occurs.
Now is the time to talk about these important issues while you can still make your own decisions and have time to talk about them with others.
If you don't have an Advance Directive and even one person interested in your care disagrees, your doctor may not honor your wishes for end-of-life care.
The Advance Directive takes the place of the former living will document and gives you more options. Review your existing forms to decide if an Advance Health Care Directive will better reflect your wishes.

WHAT DO I PUT IN MY ADVANCE DIRECTIVE?

THE KIND OF HEALTH TREATMENT YOU WANT OR DON'T WANT.
You can say whether or not you want to be kept alive by machines that breathe for you or feed you even if there is no hope you will get better.

YOUR WISHES FOR COMFORT CARE.
You can indicate whether you want medicine for pain or where you want to spend your last days. You can also give spiritual, ethical, and religious instructions.
THE PERSON OR "AGENT" YOU WANT TO MAKE DECISIONS FOR YOU WHEN YOU CANNOT.
This agent does not have to be an attorney. Unless you limit your agent's authority, your agent has the right to accept or refuse any kind of medical care and testing, discharge or select doctors, and see all medical records.

HOW CAN I ENSURE MY ADVANCE DIRECTIVE IS HONORED?

Share copies and talk with people who will be involved in your care. Ask your doctor to insert your Advance Directive into your medical records.

INSTRUCTIONS FOR ADVANCE HEALTH CARE DIRECTIVE

(in accordance with the Uniform Health Care Decisions Act, 1999)

Complete Part 1 and 2 on the enclosed form. You may add pages and make any changes you wish. You do not need an attorney to complete this form. If you need more help, consult the phone numbers included in this brochure. Complete the check list on the back page.

PART 1 – INDIVIDUAL INSTRUCTION
Give instructions to your doctor and others about any aspect of your health care. You will be given choices. Check only one box in each category and cross out all which do not apply.

PART 2 – HEALTH CARE POWER OF ATTORNEY, YOUR AGENT
Select one or more persons to be your agent and make health care decisions if you are unable. The person you appoint can be a spouse, adult child, friend, or any other trusted person. Your agent cannot be an owner or employee of a health care facility where you are receiving care unless they are related to you.
Ask two witnesses to sign and date the form
Both must be people you know. They cannot be health care providers, employees of a health care facility, or the person you choose as an agent. One person cannot be related to you or have inheritance rights.
Notary Public
If you do not have 2 witnesses, your Advance Directive must be notarized.
You have **the right to revoke or change your Advance Directive at any time** orally or in writing. Be sure to tell your agent and doctor.

WHO CAN HELP ME COMPLETE MY ADVANCE DIRECTIVE?
O'AHU: Legal Aid Society (808) 536-4302
NEIGHBOR ISANDS: Legal Aid Society (800) 499-4302
For further information contact:
Hana Hou Medical Group (808) 646-7500 website at www.hanahoumedicalgroup.com

CHECKLIST:

- [ ] Talk with family members, friends, spiritual advisors, physicians, other health-care providers and other trusted persons about what would be important to you if you become terminally or irreversibly ill or injured and you can no longer communicate your health-care decisions or other wishes.

- [ ] Ask someone you trust and whom you can count on to be your health-care agent and discuss your wishes with this person. Select an alternate health-care agent in case your agent is unable to serve.

- [ ] Complete either one of the enclosed simplified forms, change or cross out provisions or make an entirely different document. Add pages if you like.

- [ ] Have two qualified witnesses or a notary witness your signature.

- [ ] Inform family members, spouse, parents, children, siblings, friends, physicians and other health-care providers that you have executed an advance health-care directive and that you expect them to honor your instructions. Keep them informed about your current wishes.

- [ ] Give copies of the document to your health-care agent, health-care providers, family, close friends, clergy or any other individuals who might be involved in caring for you.

- [ ] Place the executed document in your medical files.

- [ ] When you renew your driver's license or state I.D, you may designate that you have an advance directive by putting (AHCD) on it.

- [ ] Make plans to review the document on a regular basis-make a new document, if necessary, and keep people informed of any changes.

- [ ] Do it today!

ADVANCE HEALTH CARE DIRECTIVE

NAME IS _____

ADDRESS IS: _____
(Address) (City) (State) (Zip code)

PART 1
DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

(1) DESIGNATION OF 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 phone) (Work phone) (E-Mail or other means of contact)

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

_____
(Name of individual you choose as first alternate agent)

_____
(Address) (City) (State) Zip code)

_____
(Home phone) (Work phone) (E-Mail or other means of contact)

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

_____
(Name of individual you choose as second alternate agent)

_____
(Address) (City) (State) Zip code)

_____
(Home phone) (Work phone) (E-Mail or other means to contact)

(2) AGENT'S AUTHORITY: **(Strike through any of the following provisions you do not want. You can add provisions on the form or attach additional pages.)**
My agent is authorized to make all of the following health care decisions for me:

a. To consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition, including admission to or discharge from a health care facility or program, approval or disapproval of diagnostic tests, medical or surgical procedures, programs of medication, the use of alternative or complementary therapies as well as decisions to participate in education, research and experimental programs.

b. To make decisions regarding orders not to resuscitate, including out-of-hospital "Comfort Care Only" documents, as well as decisions to provide, withhold, or withdraw nutrition and hydration, and all other forms of health care to keep me alive.

c. To request, receive, examine, copy, and consent to the disclosure of medical or any other health care information, including medical files and records. This includes my delegated authority for my agent to act as my personal representative for release of all individually identifiable health information concerning me by both covered and non-covered entities under the provisions of the Health Insurance Portability and Accountability Act (HIPAA) and/or other Federal and State laws pertaining to healthcare and healthcare information.

d. To communicate with, select and discharge health care providers, organizations, institutions and programs, including hospice programs and to make and change health care choices and options relating to plans, services, and benefits.

e. To apply for public or private health care programs and benefits, to include Medicare, Medicaid, Med-Quest or other federal, state, local or private programs without my agent incurring any personal financial liability.

f. To make all other health care decisions for me, except as I state here:

_____

(Consult with a mental health professional and/or attorney for appropriate language if you wish to give your agent additional information or instructions about decisions regarding mental illness. You may make a separate mental illness advance directive or include such provisions in this advance directive. Use additional sheets if needed.)

(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 unless I mark the following box.

___ ☐ If I mark this box, my agent's authority to make health care decisions for me takes effect immediately. However, I always retain the right to make my own decisions about my health care and to revoke this authority as long as I am mentally capacitated.

(4) AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, 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. My agent shall not be obligated to assume any personal financial responsibility when making decisions in accordance with this document.

(5) NOMINATION OF GUARDIAN: If a guardian of my person needs to be appointed for me by a court, I nominate my agent. If another person is appointed as guardian and my agent is willing and able to act, I would prefer my agent to have precedence in making health care decisions for me.

PART2
INSTRUCTIONS FOR HEALTH CARE

If you are satisfied with allowing your agent to determine what is best for you in making end-of-life decisions, you need not fill out this part of the form. If you do fill out this part of the form, you may strike through any wording you do not want.

(6) 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: **(Check only one of the two following boxes. You may cross out any unwanted provisions.)**

____ ☐ (a) Choice **Not To** Prolong Life

I do not want my life to be prolonged if

a. I am close to death and life support would only postpone the moment of my death or I have an incurable and irreversible condition that will result in my death within a relatively short time; or

b. I am in an unconscious state such as an irreversible coma or a persistent vegetative state and it is unlikely that I will ever become conscious again; or

c. I have brain damage or a brain disease that makes me permanently unable to interact and make and communicate health care decisions about myself and the likely risks and burdens of treatment would outweigh the expected benefits.

OR

____ ☐ (b) Choice **To** Prolong Life

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

(7) ARTIFICIAL NUTRITION AND HYDRATION: Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice I have made in paragraph (6) unless I mark the fo11owing box.

____ ☐ If I mark this box, artificial nutrition and hydration must be provided regardless of my condition and regardless of the choice I have made in paragraph (6).

(8) RELIEF FROM PAIN: If I mark the following box,

____ ☐ I direct that treatment to alleviate pain or discomfort should be provided to me even if it hastens my death.

(9) 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. Examples of additional instructions include preferences to receive Hospice Care and/or to die at home.) I direct that:

_____

PART 3
DONATION OF ORGANS/BODY AT DEATH (OPTIONAL)

(10) Upon my death: (Mark applicable box(es).

___ ☐ (a) I give any needed organs, tissues, or parts, OR

___ ☐ (b) I give the following organs, tissues, or parts only

_____

___ ☐ (c) My gift is for the following purposes
(Strike through any of the following you do not want)

a. Transplant
b. Therapy
c. Research
d. Education

___ ☐ (d) I give my body to the John A. Bums School of Medicine for its research and education purposes. **(Obtain information/forms from the medical school Department of Anatomy)**

PART4
PRIMARY PHYSICIAN/HEALTH-CARE FACILITY (OPTIONAL)

(11) I designate the following physician as my primary physician:

_____
(Name of physician)

_____
(Address) (City) (State) (Zip code) (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)

_____
(Address) (City) (State) (Zip code)
(Phone)

(12) I have the following preference of hospitals and/or nursing homes if I require such care:

_____
(You may name a facility, or you may indicate a preference for hospice care administered at home or in a hospice facility, a preference not to be institutionalized, a preference to remain at home, etc.)

PART 5
RELIGIOUS OR SPIRITUAL INFORMATION (OPTIONAL)

(13) I identify with the fo11owing church, temple, or other spiritual group:

_____

(14) I would like to receive my spiritual care from:

_____
(Name of individual or group)

_____
(Address) (City) (State) (Zip code)
(Phone)

(15) EFFECT OF COPY: A copy of this form has the same effect as the original.

SIGNATURE: **Sign and date the form here:**

_____ _____
(Sign Your Name) (Date)

_____
(Print Your Name)

WITNESSES: The power of attorney portion of this document will not be valid for making health care decisions unless it is either (a) signed by two qualified adult witnesses who are personally known to you and who are present when you sign or acknowledge your signature; or (b) acknowledged before a notary public in the state.

ALTERNATIVE NO. 1

First Witness

I declare under penalty of false swearing pursuant to section 710-1062, Hawaii Revised Statutes, that the principal is personally known to me, that the principal signed or acknowledged this power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as agent by this document, and that I am not a health care provider, nor an employee of a health care provider or facility. I am not related to the principal by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

_____ _____
(Signature of Witness) (Date)

_____ _____
(Printed Name of Witness) (Address of Witness)

Second Witness

I declare under penalty of false swearing pursuant to section 710-1062, Hawaii Revised Statutes, that the principal is personally known to me, that the principal signed or acknowledged this power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as agent by this document, and that I am not a health care provider, nor an employee of a health care provider or facility.

_____ _____

(Signature of Witness) (Date)

_____ _____

(Printed Name of Witness) (Address of Witness)

ALTERNATIVE NO. 2

State of Hawai'i
City and County of Honolulu

On this _____day of _____, in the year _____, before me,

_____(Insert name of notary public) appeared

_____, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it.

Notary Seal

_____

(Signature of Notary Public)

My Commission Expires:_____