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 _____

PART 1: HEALTH CARE POWER OF ATTORNEY
DESIGNATION OF AGENT:

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

_____
(Name and relationship of individual designated as health care agent)

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

_____
(Home phone) (Work phone) (E-Mail)

If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make decisions for me, I designate the following individual as my alternate agent:

_____
(Name and relationship of individual designated as alternate health care agent)

_____
(Address) (City) (State) (Zip code) (Home phone) (Work phone) (E-Mail)

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.

AGENT'S AUTHORITY AND OBLIGATION:
I intend my agent's authority to be as broad as possible subject only to any instructions and limitations I may state in Part 2 of this form or as I may otherwise provide orally or in writing. 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. If a guardian of my person needs to be appointed for me by a court, I nominate my agent.

PART 2: INDIVIDUAL INSTRUCTIONS FOR HEALTH CARE

A. END-OF-LIFE DECISIONS:
I wish to provide instructions regarding end-of-life decisions based on different possible situations I may face in the future.
(Strike through any of the following provisions you do not want)

- If I am close to death and life support would only postpone the moment of my death, **OR**
- If 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**
- If I have brain damage or a brain disease that makes me permanently unable to interact and to make and communicate health care decisions about myself and the likely risks and burdens of treatment would outweigh the expected benefits:

THEN

(Check only <u>one</u> of the three following boxes. You may also initial your selection)

____ ☐ (a) Choice <u>Not</u> To Prolong Life--I do not want my life to be prolonged.

OR

____ ☐ (b) Choice To Prolong Life--I want my life to be prolonged as long as possible within the limits of generally accepted health care standards. **OR**

____ ☐ (c) Choice To Be Made By Health Care Agent--! want my agent who is designated in Part 1 of this document or in a separate document to make end-of-life decisions for me.

B. <u>ARTIFICIAL NUTRITION AND HYDRATION -- FOOD AND FLUIDS</u>:

Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice I have made in the preceding paragraph A unless I mark the following 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 A.

C. <u>RELIEF FROM PAIN</u>:

___ ☐ If I mark this box, I direct that treatment to alleviate pain or discomfort should be provided to me even if it hastens my death.

D. <u>OTHER MATTERS:</u>

A copy of this form has the same effect as the original.

My agent shall not be obligated to assume any personal financial responsibility when making decisions in accordance with this document. My agent has the authority to request, receive, examine, copy and consent to the disclosure of medical or any other healthcare 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.

X_____ _____

(My Signature) (Date)

_____ _____

(My Printed Name) (My Address)

WITNESSES:
This document must either be signed by two qualified adult witnesses who witness or acknowledge the signature; or be acknowledged before a notary public in the state.

ALTERNATIVEN0.1

First Witness*

*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)

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

Second Witness**

**I am not the person appointed as agent by this document, and 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 Hawaii
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

_____