Advance Care Planning

GUIDE AND DIRECTIVE

Distributed by the **"My Life. My Way."** *Lake County Coalition for Advance Care Planning*

Sometimes it happens slowly, sometimes suddenly. But a time may come when you are unable to speak for yourself.

"My brother was suddenly diagnosed with an aggressive form of cancer that was terminal. Within 3 months of his diagnosis he couldn't communicate at all. I don't know what was worse: grieving over my brother's sudden illness, or arguing with my family members over his treatment. After he passed, I knew I wanted a less stressful situation for my children. So I now have my written instructions in a Directive. I cannot tell you what peace of mind it is for myself and a gift to my children." — Maryann Prince, LVN

The following pages clarify my wishes for medical treatment. It is also a starting point for conversations with my doctors, my spokesperson, and loved ones.

Attention Medical Personnel — Quick Reference Guide

Page 2: Spokesperson Information
Page 8–10: Optional Treatment
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Page 14–15: Signatures/Notary

My Contact Information

Today's Date: _____

Full Name: _____

Date of Birth: _____/_____/_____ Phone: (_____)_____

Street Address: _____ Apt/Unit: _____

City: _____ State: _____ Zip Code: _____

My Spokesperson: _____

My Primary Physician: _____

Preferred Hospital: _____

SECTION 1

These written instructions apply only if I am unable to speak for myself.

My Preferred Spokesperson

A spokesperson or healthcare proxy will make decisions for you if you are unable to communicate your wishes. By designating a spokesperson, you choose who will speak on your behalf. It's a good idea to first speak with the person about your goals, values, and preferences. Be sure that this person understands your wishes, and is willing to serve as a spokesperson for you.

My spokesperson is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains, except as I state here in section 7.

Spokesperson's Full Name: _____

Relationship to Me: _____

Street Address: _____ Apt/Unit: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____)_____ Mobile Phone: (_____)_____

Other Phone: (_____)_____

My Substitute Spokesperson

If the first person I named is unable, unwilling, or unavailable to act as my spokesperson, I name the following individual to be my substitute spokesperson,

Spokesperson's Full Name: _____

Relationship to Me: _____

Street Address: _____ Apt/Unit: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____)_____ Mobile Phone: (_____)_____

Other Phone: (_____)_____

Other Individuals I Would Like Involved

I would like my spokesperson (or substitute spokesperson) to talk with the following individuals before making healthcare decisions for me. These individuals may provide advice and guidance, but will NOT have veto power over my spokesperson's decisions.

List up to four individuals, or move onto the next section.

Name: _____

Relationship: _____ Phone: (_____)_____

Name: _____

Relationship: _____ Phone: (_____)_____

Name: _____

Relationship: _____ Phone: (_____)_____

Name: _____

Relationship: _____ Phone: (_____)_____

"I consider my Advance Directive a gift I give to my family."

SECTION 2

Additional Guidance For My Spokesperson

My spokesperson is authorized to make all healthcare decisions for me permitted by law, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of healthcare to keep me alive, unless I specify any limitations here:

Specify below any limitations you wish to place on your spokesperson.

_____

_____

_____

_____

Written Instructions

If you could not speak for yourself, and your spokesperson thought your care should be different than what you are choosing in this advance directive, which statement is true? *Check one box.*

- ❑ I want my spokesperson to consider my instructions, but be able to override them based on their judgment and understanding of me.
- ❑ I want my written instructions followed even if my spokesperson disagrees.

Living With Limitations

It's important that my doctor and loved ones know how I would feel about living with specific physical, mental, or social limitations — and how acceptable I would find my life if faced with each of the following circumstances. Select the response that best expresses how you feel.

1 If I were confined to bed all the time, I would consider my quality of life to be: *Check one box.*

- ❑ Acceptable
- ❑ Acceptable, but difficult
- ❑ Not worth living

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2 If I had discomfort such as nausea, diarrhea, or shortness of breath, and pain most of the time, I would consider my quality of life to be: *Check one box.*

- ❑ Acceptable
- ❑ Acceptable, but difficult
- ❑ Not worth living

3 If I could no longer make my own decisions, I would consider my quality of life to be:
Check one box.

- ❑ Acceptable
- ❑ Acceptable, but difficult
- ❑ Not worth living

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4 If I could not communicate in a way that could be understood by others, I would consider my quality of life to be:
Check one box.

- ❑ Acceptable
- ❑ Acceptable, but difficult
- ❑ Not worth living

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5 If I were so debilitated that my care caused a severe burden to my family, I would consider my quality of life to be:
Check one box.

- ❑ Acceptable
- ❑ Acceptable, but difficult
- ❑ Not worth living

"I have a healthcare directive not because I have a serious illness, but because I have a family."

— Dr. Ira Byock

SECTION 3

What Else is Important to Me

Medical decisions can be complicated, and often involve trade-offs. My preferences for medical care are based on what matters most to me. The following statements should provide helpful and detailed guidance for those who may make decisions on my behalf if I am unable to speak for myself.

6 Pain vs. Alertness

When choosing between being free from pain and being alert, I would choose:

Check one box.

❑----------❑----------❑----------❑----------❑

Freedom from pain | A balance | Being Alert

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7 Suffering vs. Living Longer

When choosing between avoiding suffering and living longer, I would choose:

Check one box.

❑----------❑----------❑----------❑----------❑

Avoiding Suffering | A balance | Living Longer

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8 Death vs. Time for Family Members

When choosing between avoiding a prolonged death and allowing time for family members to see me:

Check one box.

❑----------❑----------❑----------❑----------❑

Avoiding a prolonged death | A balance | Allowing time for my family to see me

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9 Dying at Home vs. Access to Hospital Services

When choosing between dying at home and having access to hospital services, I would choose:

Check one box.

❑----------❑----------❑----------❑----------❑

Dying at home | A balance | Access to hospital services

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10 Independence vs. Help From Others

When evaluating the trade-offs between caring for myself versus accepting help from others, I would choose to:

Check one box.

❑----------❑----------❑----------❑----------❑

Maintain my independence | A balance | Accept help from others

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11 Costs vs. Treatment

When choosing between being mindful of costs and pursuing all possible treatment options, I would choose:

Check one box.

❑----------❑----------❑----------❑----------❑

Being mindful of costs | A balance | Pursuing all options

"I need to choose my own way before I can't."

— Gabe Wind

SECTION 4

Optional Treatment / Mechanical Ventilator

A Mechanical Ventilator is a machine that assists people who cannot breathe on their own. Usually, a patient is connected to the ventilator through a tube placed in the windpipe. Mechanical ventilation is sometimes needed only for a matter of hours, but is commonly needed for much longer. Patients on ventilators are often restrained in bed and sedated. Almost 2/3 of people placed on mechanical ventilation will recover enough to get off it.

13 If there was a reasonable chance to preserve what I consider a good quality of life:
Check one box.

- ❑ I would want Mechanical Ventilation.
- ❑ I would NOT want Mechanical Ventilation (or CPR)
- ❑ I'm not sure

Optional Treatment / CPR

Cardiopulmonary resuscitation (CPR) is an emergency procedure consisting of chest compressions and artificial respiration, and is the first treatment for a person who has collapsed, has no pulse, and has stopped breathing. The goal of CPR is to prevent death by restoring blood flow and by providing oxygen to the lungs. While some people recover fully after CPR, most die. Less than 20% typically survive, younger and healthier people are more likely to do well. People who are older and more frail are more likely to suffer complications like rib fractures. Many survivors are left with brain damage that can profoundly diminish their ability to function.

14 If there was a reasonable chance to preserve what I consider a good quality of life:
Check one box.

- ❑ I would want CPR
- ❑ I would NOT want CPR
- ❑ I'm not sure

Optional Treatment / Feeding Tube

Feeding tubes are usually most helpful after a stroke, when people are not able to eat without food going into their lungs. A tube can be placed in the nose for up to a couple of weeks. Often people who can't communicate are confused, so their hands have to be tied down to prevent them pulling the tube out. If they are not able to swallow safely within a couple of weeks they can have a minor surgery to place a feeding tube through the front of their belly. This can provide nutrition for a lifetime.

When ability to swallow is lost for some reason that is not reversible, feeding tubes generally have been shown to not help. In fact, they result in a person receiving less attention, increased chance of being tied down, and increased chance of bedsores.

15 If I couldn't communicate and couldn't safely eat, I would prefer:
Check one box.

- ❑ Long-term artificial nutrition, including feeding tubes
- ❑ A trial period of short-term artificial nutrition
- ❑ No artificial nutrition including feeding tubes

SECTION 5

Planning For Comfort Care

The term "comfort care", also known as Palliative Care, means not only relieving pain and symptoms but caring for your physical, emotional, social and spiritual needs. *Answer the following questions to help your loved ones understand what you need to be comfortable.*

Palliative Care:
If I have a serious illness, I would like to receive Palliative Care if I am eligible, and it is available.
❑ Yes ❑ No

"You matter because you are you. You matter to the last moment of your life..."

— Dame Cicely Saunders, founder of the modern hospice movement

Hospice Care:
If I have been given a terminal diagnosis and choose to focus on comfort care, I would like to have care provided under the guidance of a Hospice agency.

❑ Yes ❑ No

Medication:
Check the box next to one of the answers below.

❑ I prefer that enough pain medication be given to me to keep me comfortable, even if this means I am not fully aware of what is going on.

❑ I prefer that I be medicated for pain but also want to be aware of my surroundings and what is going on. I understand this may mean my pain control may not be complete. (Again, this applies when I cannot speak for myself.)

Special People:
Record the names of special people or pets whose presence would comfort you.

Family members: _____

Special people and/or pets: _____

Members of my faith community: _____

Someone to be with me at the time of my death if possible: _____

"Most people want to die in comfort and peace, with time for friends and family to say good bye. When we can open dialogues with our loved ones about our desires and needs for how we want to leave this world, we can start creating peaceful endings."

— Diane Pege, MD, MMM, FACP

SECTION 6

Making Your Wishes Matter

The following are examples of situations in which you would not be able to speak for yourself and others would have to make decisions for you. Please select the type of treatment you would want in that situation.

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16 If I'm unconscious, in a coma, or in a persistent vegetative state and there is little or no chance of recovery, the type of care I would want is:
Check one box.

❑----------❑----------❑----------❑----------❑

Comfort Treatment Only | Optional Treatment | No Limits

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17 If I have permanent severe brain damage (for example, severe dementia) that makes me unable to recognize my friends or family, the type of care I would want is:
Check one box.

❑----------❑----------❑----------❑----------❑

Comfort Treatment Only | Optional Treatment | No Limits

---

18 If I have a permanent condition that makes me completely dependent on others for my daily needs (for example — eating, bathing, toileting), the type of care I would want is:
Check one box.

❑----------❑----------❑----------❑----------❑

Comfort Treatment Only | Optional Treatment | No Limits

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19 If I'm confined to bed and need a breathing machine to support my breathing for the rest of my life, the type of care I would want is:
Check one box.

❑----------❑----------❑----------❑----------❑

Comfort Treatment Only | Optional Treatment | No Limits

SECTION 7

Organ Donation

20 When I think about organ and tissue donation:
Check one box.

- ❑ I would want to donate any organs or tissues
- ❑ I would want to donate organs or tissues, but with exceptions
- ❑ I would NOT want to donate any organs or tissues

Any exceptions for organ and tissue donations are detailed here (for example: internal organs, eyes, etc.):

_____

_____

_____

SECTION 8

Other

_____

_____

_____

"Choosing my spokesperson turned out to be an eye-opening experience for me. I knew I needed someone who could advocate for what I wanted, and not be too emotional — which weeded out my immediate family! I turned to my long-time friend who said 'absolutely'."

— Joan and Eileen

SECTION 9

1 Make it official.

You have completed your Advance Directive, and made an important investment in living — on your terms.

To make this a LEGAL document:

- Review your Advance Care Plan and make any edits.
- Sign the signature form on the next few pages in the presence of two witnesses or have it notarized.

2 Discuss your Advance Directive with others.

Filling out an advance directive is not enough to ensure that your wishes will be followed. These documents are not useful if locked up in a safety deposit box or hidden away in a file cabinet. For advance care planning to be effective, you need to discuss your wishes and share your documents with friends, family members, doctors, and others who can help make sure that your wishes are followed.

What if you change your mind?

You can change your written instructions at any time, and it's a good idea to revisit them every couple of years or if your medical condition changes. Please know that these written instructions apply only if you are not able to speak for yourself.

Signing Your Advance Directive

To Make your Advance Directive legal, please complete the following 3 steps:

1. Print your name and date. Then sign in the designated areas on the next page in front of TWO witnesses OR acknowledged before a notary public who meet all of the requirements listed on the next page.
2. Have your two witnesses OR notary complete and sign in the designated areas on the next page.
3. Attach these pages to the end of your completed Advance Directive and share it with your family, spokesperson, and medical provider.

Your Signature

I, _____, ask that my family, loved ones, doctors, and healthcare providers follow my wishes as communicated by my spokesperson or as otherwise expressed in my Advance Directive.

Signature: _____ Today's Date: _____

Witness Signature (2 witnesses needed)

Witness #1 and #2

I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this ADVANCE 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 his/her 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 designated as health care proxy, 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.

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this ADVANCE 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.

#1 Signature: _____ Today's Date: _____

Printed Name: _____

Street Address: _____ Apt/Unit: _____

City: _____ State: _____ Zip Code: _____

Phone: (_____)_____

#2 Signature: _____ Today's Date: _____

Printed Name: _____

Street Address: _____ Apt/Unit: _____

City: _____ State: _____ Zip Code: _____

Phone: (_____)_____

Notarization (optional)

California All Purpose Acknowledgement

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document, and not the truthfulness, accuracy, or validity of that document.

State of CALIFORNIA County of _____

On this _____ before me,_____Notary Public

Date _____(here insert name and title of the officer) _____

personally appeared: _____

_____

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) _____

_____OPTIONAL _____

Description of Attached Document

Title or Type of Document: _____ Number of Pages: _____

Document Date: _____ Other:_____

My Life. My Way.

LAKE COUNTY COALITION FOR ADVANCE CARE PLANNING

Committed to supporting Lake County residents in deciding and documenting the options for health care you want if you cannot speak for yourself.

Whether you're 35, 55, or 85, it's a good time to ensure that you and your family are prepared in the event of a health crisis or terminal medical diagnosis.

It's the gift you give your loved ones and yourself.

Visit www.MyLifeMyWay.Life
to find out about upcoming informational sessions on
Advance Care Planning

Adventist Health Clear Lake

Hospice Services of Lake County
HOPE • COMPASSION • LIFE

Lake County Tribal Health
Modern Medicine Personalized Care

LAKEPORT POST ACUTE

LAKEVIEW HEALTH CENTER

Meadowood Nursing Center

Rocky Point Care Center

Sutter Health
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