Life Activities

Please complete the following list which we will be using as part of the morning session at our Hoag Seminar for Faith Leaders.

In no particular order of importance, identify 3 to 5 different activities under each category that you currently enjoy doing. Include the things that you do in the fullness of your being that make your life worth living.

Relational (eg. Eating out with friends, playing with grandchildren)

Recreational (eg. Physical activities such as tennis, biking, gardening)

Intellectual (eg. Reading, attending theater)

Vocational (eg. Pastoral counseling, preaching, ministry)

Avocational (eg. Knitting, playing an instrument)

Spiritual (eg. Attending church, meditation/prayer, Bible study)
People have personal priorities and spiritual beliefs that effect their medical decisions. This is especially true at the end of life with regard to the use of life-sustaining treatments. To make your values and beliefs clearer, consider answering the questions below. Use more paper if you need more space.

**Personal Priorities/Concerns**

1. What do you most value about your physical or mental well being? For example, do you most love to be outdoors? To be able to read or listen to music? To be aware of your surroundings and who is with you? Seeing, tasting, touching?

2. What are your fears regarding the end of life?

3. Would you want to be sedated if it were necessary to control your pain, even if it makes you drowsy or puts you to sleep much of the time?

4. Would you want to have a hospice team or other palliative care (i.e., comfort care) available to you?

5. If you could plan it today, what would the last day or week of your life be like? For example
   - Where would you be? What would your environment be like?
   - Who would be present?
   - What would you be doing?
   - What would you eat if you could eat?
   - What would be your final words or last acts?
6. Are there people to whom you want to write a letter or for whom you want to prepare a taped message, perhaps marked for opening at a future time?

7. How do you want to be remembered? (If you wrote your own epitaph or obituary, what would it say?)

8. What are your wishes for a memorial service – for example, the songs or readings you want, or the people you hope will participate?

**SPIRITUAL/RELIGIOUS MATTERS OF IMPORTANCE TO YOU**

9. How would you describe your spiritual or religious life?

10. What gives your life its purpose and meaning?

11. What is important for others to know about the spiritual or religious part of your life?

12. What do you need for comfort and support as you journey near death? For example, to pray with a member of the clergy? To have others pray for you? To be read to from spiritual or religious texts? To have music playing in your room? To be held?

13. Other priorities/values you want others to know.
Advance Health Care Directive Form
Instructions

You have the right to give instructions about your own health care.

You also have the right to name someone else to make health care decisions for you.

The Advance Health Care Directive form lets you do one or both of these things. It also lets you write down your wishes about donation of organs and the selection of your primary physician. If you use the form, you may complete or change any part of it or all of it. You are free to use a different form.

INSTRUCTIONS

Part 1: Power of Attorney

Part 1 lets you:

• name another person as agent to make health care decisions for you if you are unable to make your own decisions. You can also have your agent make decisions for you right away, even if you are still able to make your own decisions.
• 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.
• your supervising health care provider (the doctor managing your care)
• an employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.

Your agent may make all health care decisions for you, unless you limit the authority of your agent. You do not need to limit the authority of your agent.

If you want to limit the authority of your agent the form includes a place where you can limit the authority of your agent.

If you choose not to limit the authority of your agent, your agent will have the right to:

• Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.

Choose or discharge health care providers (i.e. choose a doctor for you) and institutions.

Agree or disagree to diagnostic tests, surgical procedures, and medication plans.

Agree or disagree with providing, withholding, or withdrawal of artificial feeding and fluids and all other forms of health care, including cardio-pulmonary resuscitation (CPR).

After your death make anatomical gifts (donate organs/tissues), authorize an autopsy, and make decisions about what will be done with your body.

Part 2: Instructions for Health Care

You can give specific instructions about any aspect of your health care, whether or not you appoint an agent.

There are choices provided on the form to help you write down your wishes regarding providing, withholding or withdrawal of treatment to keep you alive.

You can also add to the choices you have made or write out any additional wishes.

You do not need to fill out part 2 of this form if you want to allow your agent to make any decisions about your health care that he/she believes best for you without adding your specific instructions.
Part 3: Donation of Organs

You can write down your wishes about donating your bodily organs and tissues following your death.

Part 4: Primary Physician

You can select a physician to have primary or main responsibility for your health care.

Part 5: Signature and Witnesses

After completing the form, sign and date it in the section provided.

The form must be signed by two qualified witnesses (see the statements of the witnesses included in the form) or acknowledged before a notary public. A notary is not required if the form is signed by two witnesses.

See part 6 of the form if you are a patient in a skilled nursing facility.

Part 6: Special Witness Requirement

A Patient Advocate or Ombudsman must witness the form if you are a patient in a skilled nursing facility (a health care facility that provides skilled nursing care and supportive care to patients).

See Part 6 of the form.

You have the right to change or revoke your Advance Health Care Directive at any time

If you have questions about completing the Advance Directive in the hospital, please ask to speak to a Chaplain or Social Worker.

We ask that you complete this form in English so your caregivers can understand your directions.
Advance Health Care Directive

Name________________________________________

Date________________________________________

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form also lets you write down your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may complete or change all or any part of it. You are free to use a different form.

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

Part 1 — Power of Attorney for Health Care

(1.1) 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:________________________________________

Relationship__________________________

Address: ________________________________________________________________

Telephone numbers: (Indicate home, work, cell) ________________________________

ALTERNATE AGENT (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 alternate agent:______________________________

Relationship__________________________

Address: ________________________________________________________________

Telephone numbers: (Indicate home, work, cell) ________________________________

SECOND ALTERNATE AGENT (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: ________________________________________________________________

Telephone numbers: (Indicate home, work, cell) ________________________________
(1.2) AGENT’S AUTHORITY: My agent is authorized to 1) 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 to keep me alive, 2) choose a particular physician or health care facility, and 3) receive or consent to the release of medical information and records, 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 unless I initial the following line.

If I initial this line, I want my agent to make health care decisions for me immediately even though I am still able to make them for myself. ____

(1.4) 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 my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(1.5) 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 or in Part 3 of this form:

(Add additional sheets if needed.)

(1.6) 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 not willing, able, or reasonably available to act as conservator, I nominate the alternate agents whom I have named. ______ (initial here)

Part 2 — Instructions for Health Care

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

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

☐ a) Choice Not To Prolong
I do not want my life to be prolonged if the likely risks and burdens of treatment would outweigh the expected benefits, or if I become unconscious and, to a realistic degree of medical certainty, I will not regain consciousness, or if I have an incurable and irreversible condition that will result in my death in a relatively short time.
Or
☐ b) Choice To Prolong
I want my life to be prolonged as long as possible within the limits of generally accepted medical treatment standards.
(2.2) OTHER WISHES: If you have different or more specific instructions other than those marked above, such as: what you consider a reasonable quality of life, treatments you would consider burdensome or unacceptable, write them here.

(Add additional sheets if needed.)

Part 3 — Donation of Organs at Death (Optional)

(3.1) Upon my death (mark applicable box):

☐ I give any needed organs, tissues, or parts

☐ I give the following organs, tissues or parts only: ______________________________________

☐ I do not wish to donate organs, tissues or parts.

My gift is for the following purposes (strike out any of the following you do not want):

Transplant    Therapy    Research    Education

Part 4 — Primary Physician (Optional)

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

Name of Physician: ________________________________________________________________

Address: _______________________________________________________________________

_______________________________________________________________________________

Telephone: __________________________

Part 5 — Signature

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

(5.2) SIGNATURE: Sign name: __________________________________________ Date: __________

(5.3) 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
Print Name:
Address:
Signature of Witness: _______________________________ Date: _________________

SECOND WITNESS
Print Name:
Address:
Signature of Witness: _______________________________ Date: _________________

(5.4) 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 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 on his or her death under a will now existing or by operation of law.
Signature of Witness: _______________________________
Signature of Witness: _______________________________

Part 6 — Special Witness Requirement if in a Skilled Nursing Facility
(6.1) 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:
Print Name: ___________________________ Signature: ___________________________
Address: _______________________________ Date: _________________

Certificate of Acknowledgement of Notary Public (Not required if signed by two witnesses)
State of California, County of ______________________________
On this ___________________________ (date) before me ________________________________, Notary Public, 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. Seal

Signature of Notary _______________________________