Sugai & Sudweeks, LLP

200 South Santa Cruz Ave., Suite 100
Los Gatos, California 95030
(tele) 408-354-0200 408-354-7779 (fax)

Leslie Yarnes Sugai, Esq.*†
Sheri Sudweeks, Esq.*
www.sugaisudweeks.com

MEMORANDUM TO CLIENT REGARDING
ADVANCE HEALTH CARE DIRECTIVE

Client Name:_____ Date:_____

Please read the Advance Health Care Directive Explanation which accompanies this memo.

Agent

Name: _____
Address: _____
_____
Telephone: _____

First Alternate Agent

Name: _____
Address: _____
_____
Telephone: _____

Second Alternate Agent

Name: _____
Address: _____
_____
Telephone: _____

Please complete this memo as follows:
Enter above the details of person(s) you wish to make Health Care decisions for you in the event of your becoming incapacitated. Please select only **ONE** in each category**.**

Part 1	Period during which Agent's authority is effective	- Select either A **or** B
	Expiration	- Enter date if so desired (not recommended)
	End of Life Decisions	- Select either A, B, C, D **or** E
	Relief from Pain	- Initial if desired
	Hydration and Nutrition	- Initial if desired
	Additional Statement of Desires	- Complete if desired
		-
Part 2	Anatomical Gifts – Disposition of Organs, Tissues or parts (qualify if desired)	- Select either A, B **or** C
	Power to direct disposition of remains	- Select either A, B **or** C
	Arrangements for Funeral or Memorial Service	- Initial if desired
	Authorization for Autopsy	- Select either A **or** B
Part 3	INSTRUCTIONS FOR PERSONAL CARE	
	Independent Living; Social Interaction; Religious or Spiritual Activity; Outdoor Activity	- Initial any of the statements you wish to have included
	Nomination of Conservator of Person	- Enter details
	Designation of Primary Physician	- Initial if desired
	Agents of Authority to Select Physician	- Initial if desired

PART 1

Please select **ONE** of the following and initial:

PERIOD DURING WHICH AGENT'S AUTHORITY IS EFFECTIVE

A. My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions. My agent's authority ceases to be effective when my primary physician determines that I am able to make my own health care decisions.

_____
Initials

B. My agent's authority to make health care decisions for me takes effect immediately.

_____
Initials

EXPIRATION

Unless you choose to limit the duration of your Advance Health Care Directive, the Directive will be valid indefinitely. We recommend that you not limit the duration. However, if you choose to limit the duration (and enter an expiry date below), you will have to create a new Directive after the expiration date.

This advance health care directive expires on _____

INSTRUCTIONS FOR HEALTH CARE

Please select **ONE** of the following and initial:

END OF LIFE DECISIONS

A. No Treatment Which Merely Prolongs Inevitable Death

I recognize that modern medical technology has made possible the artificial prolongation of my life beyond natural limits. I do not wish to artificially prolong the process of my dying if continued health care will not improve my prognosis for recovery or otherwise enable me to live a productive and/or enjoyable life. Therefore, I do not want efforts made to prolong my life and I do not want life-sustaining treatment to be provided or continued (1) if I am in an irreversible coma or persistent vegetative state; or (2) if I am terminally ill and the use of life-sustaining procedures would serve only to artificially delay the moment of my death; or (3) under any other circumstances in which the burdens of the treatment outweigh the expected benefits. By "an irreversible coma," I mean a coma from which the treating physicians have reasonably concluded I will never regain consciousness. In making decisions about life-sustaining treatment under provision (3) above, I want my agent to consider the relief of suffering and quality of remaining life as well as the extent of the possible prolongation of my life.

_____
Initials

B. Treat Unless in Irreversible Coma

I want to receive medical treatment that prolongs and sustains my life unless I am in an irreversible coma. By an "irreversible coma" I mean a coma from which the treating physician or physicians have reasonable concluded I will never regain consciousness. If I am in such an irreversible coma, I do not want to receive medical treatment that prolongs and sustains my life.

_____
Initials

C. No Life-Sustaining Procedures if in Terminal Condition

If I am in a terminal condition, I do not want any life-sustaining procedures to be used to prolong my life. For purposes of this document, (1) "terminal condition" shall mean an incurable condition caused by injury, disease or illness, which, regardless of the application of life-sustaining procedures, would, within reasonable medical judgment, produce death and in which the application of life-sustaining procedures serves only to postpone the moment of my death; and (2) "life-sustaining procedures" shall mean any medical procedure or intervention that utilizes mechanical or other artificial means to sustain, restore or supplant a vital function which will serve only to artificially prolong the moment of my death. The term "life-sustaining procedures" shall not include the administration of medication or the performance of any medical procedure deemed necessary to alleviate pain.

_____
Initials

D. Treat to Allow Life as Long as Possible

I want to live as long as possible; therefore, I want to receive all medical treatment that will prolong and sustain my life within the limits of generally accepted health care standards. I want such treatment provided to me regardless of my chances of recovery, my condition, or the cost of such treatment.

_____
Initials

E. No Statement of Desires

_____
Initials

RELIEF FROM PAIN (OPTIONAL)

I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death. I wish to receive any other forms of palliative care that may ease my suffering.

_____
Initials

HYDRATION AND NUTRITION (OPTIONAL)

I direct that when life-sustaining procedures or treatment are withheld or withdrawn, that hydration and nutrition also be withheld or withdrawn when they are the only means by which my life is being sustained unless necessary for my comfort or alleviation of pain.

_____
Initials

ADDITIONAL STATEMENT OF DESIRES (OPTIONAL)

OTHER WISHES:

_____
_____
_____

_____
Initials

PART 2

ANATOMICAL GIFTS

Disposition of Organs, Tissues or Parts

A. Upon my death, my agent may donate any organs, tissues or parts.

_____
Initials

B. Upon my death, my agent may donate only the following organs, tissues or parts:
_____

This gift shall be for the following purposes only:
_____
_____

_____
Initials

C. Upon my death, my agent may not donate any organs, tissues or parts.

_____
Initials

Please select one of the following and initial:

POWER TO DIRECT DISPOSITION OF REMAINS

A. My agent shall have the power and authority to direct the disposition of my remains according to his/her discretion.

_____
Initials

B. My agent shall have the power and authority to direct the disposition of my remains according to my desires as follows:
_____
_____

_____
Initials

C. My agent shall not have the power or authority to direct the disposition of my remains.

_____
Initials

ARRANGEMENTS FOR FUNERAL OR MEMORIAL SERVICES (OPTIONAL)

My agent shall have the power and authority to arrange for my funeral or other memorial service.

_____
Initials

Please select one of the following and initial:

AUTHORIZATION OF AUTOPSY

A. My agent shall have the power and authority to authorize an autopsy.

_____
Initials

B. My agent shall not have the power or authority to authorize an autopsy.

_____
Initials

PART 3

INSTRUCTIONS FOR PERSONAL CARE

INDEPENDENT LIVING

I wish to live in my home for as long as that is reasonably possible without endangering my physical or mental health and safety, and to receive whatever assistance from household employees or personal care givers as may be necessary to permit me to do so, *provided, however, that in the event my agent determines that appropriate household employees or personal care givers are not available without putting my financial position or physical or mental health or safety at risk, then I wish to live in the least restrictive and most home-like setting deemed appropriate by my agent. I further request that I live as near as possible to my primary residence in order that I may visit with friends and neighbors to the degree my agent believes that I will benefit from such relationships.*

I wish to return home as soon as reasonably possible after any hospitalization or transfer to convalescent care. If my agent determines that I am no longer able to live in my home, I wish that my agent consider alternatives to convalescent care which will permit me as much privacy and autonomy as possible, including such options as placing me in an assisted living facility or board and care facility.

THE LANGUAGE INCLUDED IN THE ABOVE PARAGRAPH IN *ITALICS* IS OPTIONAL. IF YOU WOULD LIKE TO INCLUDE THIS LANGUAGE, PLEASE INITIAL BELOW.

_____
Initials

SOCIAL INTERACTION (OPTIONAL)

I wish to be encouraged to maintain my social relationships and to engage in social interaction even if I am no longer able to recognize my family and friends or to fully participate in social activities.

_____
Initials

Please select and initial as desired.

RELIGIOUS OR SPIRITUAL ACTIVITY (OPTIONAL)

My involvement with _____ has been very important to me. I wish to maintain that involvement as long as possible, even if I no longer fully appreciate its significance. To that end, in accordance with my established beliefs and customary activities, my agent shall provide for the presence and involvement of clergy or other persons to attend to my spiritual needs and permit them access to me and shall arrange for my access to activities and publications, including books, tapes and similar materials, associated with my spiritual involvement.

_____
Initials

My agent shall not in any way impose his/her religious beliefs, or the religious beliefs of others, on me.

_____
Initials

OUTDOOR ACTIVITIES (OPTIONAL)

I wish to spend significant time outdoors. If I can no longer travel, I wish my agent to arrange for trips to local parks and other areas where I may be outdoors in a natural setting.

_____
Initials

NOMINATION OF CONSERVATOR OF PERSON

If a conservator of the person is to be appointed for me, I nominate the following individual to serve as conservator of the person:

_____ Agent authorized by this AHCD

_____ Other:

Name: _____
Address:_____
_____
Telephone: _____

Designation of Primary Physician

I wish to designate a primary physician.

_____
Initials

Agents Authority to Select Physician

I wish to give my agent authority to select a primary physician.

_____
Initials

ADVANCE HEALTH CARE DIRECTIVE – EXPLANATION

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 lets you do either or both of these things. It also lets you express your wishes regarding your personal care, donation of organs, and the designation of your primary physician.

Part I of the Advance Health Care Directive is a Power of Attorney for Health Care. Part I of the attached memorandum lets you 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 those decisions for you now, even though you are still capable. You may also name an alternative 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 residential care facility where you are receiving care, or your supervising health care provider or employee of the health care institution where you are receiving care, unless your agent is related to you or is a co-worker.)

Unless you choose to limit the authority of your agent, your agent may make all health care decisions for you and all decisions regarding your personal care. You do not need to limit the authority of your agent if you wish to rely on your agent for all health care decisions and personal care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

a) Consent or refuse consent to any care, treatment, service or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.
b) Select or disapprove health care providers and institutions.
c) Approve or disapprove diagnostic tests, surgical procedures, and programs of medication.
d) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.
e) Make anatomical gifts, authorize an autopsy, and direct disposition of remains.
f) Make personal care decisions, including determining where you will live, providing meals, hiring household employees, providing transportation, handling mail, and arranging recreation and entertainment for you.

Part I of the attached memorandum lets you provide specific instructions for your Advance Health Care Directive about any aspect of your health care, including the provision, withholding, or withdrawal of treatment to keep you alive, as well as the provision of pain relief. You can also provide instructions with regards to nutrition and hydration and any other desires.

Part II of the attached memorandum also allows you to direct your agent with regards to the donation of organs, disposition of remains and funeral and memorial service arrangements.

Part III of the attached memorandum lets you provide specific instructions for your Advance Health Care Directive about any aspect of your personal care. These choices include instructions with regards to your religious and spiritual activities and outdoor activities.

After completing the attached memorandum, return it to us. We will use it when preparing your Advance Health Care Directive. Once drafted, the Advance Health Care Directive will be signed and acknowledged before a Notary Public. We will provide you with copies of the signed and completed form to give to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health care agents you have named. You should talk to the person you have named as your agent to make sure that he or she understands your wishes and is willing to take the responsibility.

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