my care

Advance Directive: Understanding and honoring my future health care goals

My Care, My Choices

You might be healthy now, but what if you became very sick or injured in the future and couldn't speak for yourself?

How would doctors, nurses, and your loved ones know what kind of health care you would like to receive?

In Santa Barbara County, your health care providers want to understand and honor your values and health care goals.

We encourage everyone in our community to do advance care planning.

Advance Care Planning

Advance care planning is a helpful way for people of all ages to prepare for the future. Both healthy people and people with health conditions do advance care planning.

Advance care planning is:

- Making decisions now about the types of health care you would and would not want to receive if you become very sick or injured and couldn't speak for yourself in the future
- Choosing a person you want to make decisions for you if you're unable to do so for yourself. This person is called a health care agent
- Talking with your doctors and loved ones about the types of health care you want to receive so they'll respect and honor your values and health care goals
- Writing down your health care goals in MyCare, an advance directive. This form guides your health care providers as to what types of health care you want. It also helps your loved ones understand your wishes in case they have to make health care decisions for you

PAGES 1-2
Information about advance care planning, advance directives, and health care agents

PAGE 3
Your values and what is important to you in your life **(OPTIONAL)**

PAGES 4-5
Your wishes and preferences to help guide your health care agent in making decisions **(OPTIONAL)**

PAGES 6-8, REQUIRED
Your information and health care agent information

PAGES 9-11, REQUIRED
Your health care instructions

PAGES 12-14, REQUIRED
Signatures to make this document legal

PAGES 15-17
Next steps to share your wishes and this document with others and write additional notes **(OPTIONAL)**

Full name:

What is an advance directive?

An advance directive is a legal form you fill out that says:

- The types of medical care you would like to receive if you are very sick or injured and cannot speak for yourself
- The name and contact information of the person you chose to be your health care agent

MyCare is an advance directive used throughout Santa Barbara County. Community members can also use other types of advance directives, and they will be honored.

When should you complete or review your advance directive?

- When you get your driver's license
- When you form a long-term relationship
- When you have a child
- When you have a high-risk job
- When you belong to the military
- When you retire
- When you sign up for Medicare
- When you have your annual physical
- When you have a health condition
- When you're close to the end of your life

Can you change your advance directive?

You can change your advance directive anytime. If you want to change or cancel your advance directive, you can:

- Change it in writing and sign that document
- Personally tell your doctor the changes you want to make
- Fill out a new advance directive
- Give new copies to your doctor, loved ones, and health care agent
- Destroy the old copies so your doctors, loved ones and health care agents don't get confused

Full name:

Who is a health care agent?

A health care agent is the person you choose to make health care decisions for you if you're unable to speak for yourself.

- It's important you talk to your health care agent about the types of health care you would want and wouldn't want so your health care agent understands and agrees to honor your decisions
- If your decisions are not known, your health care agent will make decisions based on what he or she thinks is best for you

How many people can be your health care agent?

It is recommended that you choose only one person to be your health care agent. This way decisions can be made quickly, and it helps avoid disagreements.

You can choose a second and third person to be your health care agent in case your first health care agent is unavailable. Be sure to discuss your health care decisions with your second and third health care agents too.

When does your health care agent make decisions for you?

For most people, a health care agent only makes health care decisions for you if you're unable to speak for yourself.

Some people want their health care agent to make health care decisions for them even if they are able to decide or speak for themselves. If you'd like your health care agent to make decisions for you now, you can write that in your advance directive.

What types of decisions does a health care agent make for you?

- Choosing your doctors and where you'll receive care
- Speaking with your medical providers
- Deciding what tests, medicine, and surgery you could have
- Planning for your medical care in California or another state
- Reviewing and releasing your medical record
- Planning for your care in a nursing home or residential care facility
- Making arrangements if you die
- Having an autopsy

Who can be your health care agent?

A family member, friend or someone who:

- Is 18 years or older
- Knows you well
- Agrees to accept this responsibility
- Can be trusted to honor your wishes and values
- Can make difficult decisions in stressful situations
- Can be calm and think clearly when talking with your medical providers, family, and friends
- Can be contacted easily by your medical providers

Who cannot be your health care agent?

- Your doctor
- Someone who works at the hospital, clinic, or facility where you receive medical care, unless he or she is a family member or registered domestic partner

Full name:

My Values

This section is recommended. You can attach more pages if necessary.

I want my health care agent and my loved ones to know what matters most to me so they can make decisions about my health care that match who I am and what is important to me.

I'd like to tell you some things about myself such as:

- How I like to spend my time
- Who I like to spend time with
- What I like to do in my life
- What would make my life no longer worth living

1. If I were having a really good day, I would be doing the following:

2. What matters most to me in my life is:

3. My life would no longer be worth living if I could not:

Full name:

My Wishes and Preferences

This section is recommended. You can attach more pages if necessary.

1. After my death, I would like to be:
   - ☐ cremated
   - ☐ buried
   - ☐ I don't have a preference
   - ☐ I have already made the following plan:

1. I would prefer to die in the following place:
   - ☐ hospital
   - ☐ skilled nursing facility
   - ☐ hospice
   - ☐ home
   - ☐ other: .....

3. If I am close to dying, I want my loved ones to know that I would like these types of comfort and support listed below (people, prayers, readings, rituals, music, etc):

Full name:

4. Religious or spiritual beliefs:

   My faith/spiritual tradition:

   My faith/spiritual community:

   Address:

   Phone:

   I would like my faith/spiritual community contacted if I am very sick, injured or dying.

   ☐ YES ☐ NO

   Additional Notes:

5. In my memorial service, I would like to include the following (people, music, rituals, readings, etc):

6. Other wishes/instructions:

Full name:

My Information and Health Care Agent

I, _____,
(FULL NAME)

make this document my advance directive. I revoke any prior Advance Health Care Directive, Power of Attorney for Health Care or Natural Death Act Declaration.

My full name (first, middle, last):

Date of birth:

Street address:

City/State/Zip:

Home phone: Cell phone:

Work phone: Email:

MY HEALTH CARE AGENT

If I'm unable to make health care decisions for myself, the person I have chosen below to be my health care agent will make health care decisions for me:

Full name (first, middle, last):

Relationship to me:

Home phone: Cell phone:

Work phone: Email:

Street address:

City/State/Zip:

REQUIRED – My Information and Health Care Agent

Full name:

If the first person I listed cannot make health care decisions for me, then the second person I want to be my health care agent and make health care decisions for me is:

Full name (first, middle, last):

Relationship to me:

Home phone: Cell phone:

Work phone: Email:

Street address:

City/State/Zip:

If the first and second person(s) cannot make decisions for me, then the third person I want to be my health care agent and make decisions for me is:

Full name (first, middle, last):

Relationship to me:

Home phone: Cell phone:

Work phone: Email:

Street address:

City/State/Zip:

Full name:

I WANT MY HEALTH CARE AGENT TO:

_____ Decide what tests, medicine, and surgery I have

_____ Choose my doctors and the locations where I'll receive care

_____ Speak with my health care providers

_____ Plan for my health care in California or another state

_____ Review and release my medical records

_____ Plan for my care in a nursing home or residential care facility

_____ Make decisions about organ/tissue or body donation after I die

_____ Make plans for my body after I die (including autopsy)

INSTRUCTIONS:

If you **agree** with the statement, initial the authorization line.

OR

If you **do NOT agree** with the statement, cross it out and initial it.

Additional information about what my health care agent CAN and CANNOT do:

MY HEALTH CARE AGENT'S AUTHORITY TO MAKE DECISIONS FOR ME:

Initial the line or lines below if you want your health care agent to also have these responsibilities.

_____ Begins when my doctor determines I am unable to make my own health care decisions

_____ Begins immediately, but my health care agent cannot make a health care decision for me if I do not agree with that decision

Please provide any additional comments or restrictions here about your health care agent:

Full name:

My Health Care Instructions

If I am unable to communicate or make my own choices, this form states my directions.

A. LIFE SUSTAINING TREATMENTS TO KEEP YOU ALIVE LONGER

To help you explain your health care decisions to your medical team, health care agent, and loved ones, consider the situation below in which a sudden, unexpected event happens that makes you very ill or injured. You are unable to speak for yourself.

> ***You have a sudden accident or stroke.*** *Doctors find you have a brain injury. You do not know who you are or your loved ones are. The doctors tell your health care agent and/or loved ones they do not think you will recover. Life-sustaining treatments are necessary to keep you alive.*

Life sustaining treatments could include:

- **Ventilator:** a machine that breathes for you when your lungs aren't working. A tube is inserted either through your mouth or an incision in your neck into your airway. The tube connects to the machine. This tube may feel uncomfortable, and the nurses may give you medicine to help you. You cannot talk or eat normally when a breathing tube is in place
- **Feeding tube:** a plastic tube that is put inside your nose or into your stomach through a small incision. This plastic tube gives you food and water
- **Dialysis machine:** a machine that removes waste from your blood if your kidneys aren't working

In this situation what would you want?

I would want to be kept comfortable AND (choose one by initialing on the line provided):

_____ I want to STOP life-sustaining treatment. I realize this would probably cause me to die sooner.

_____ I want to continue life-sustaining treatment only for the purpose of organ or tissue donation.

_____ I want to continue life-sustaining treatment.

Full name:

If you have other instructions about life sustaining treatments, you can provide them here:

B. CPR (CARDIOPULMONARY RESUSCITATION)

If your heartbeat and/or breathing stop, CPR can be done to try to revive you. CPR may include:

- Chest compressions (forceful pushing on the chest to make the heart beat again)
- Medicine
- Electrical shocks
- Breathing tube

You have a choice about whether you would like CPR. CPR can save lives, but it's important to know these facts:

- CPR works best if done within a few minutes on a healthy adult
- While CPR may restart the heart, it may not return even people who are otherwise healthy to their previous state of health
- The success rate of CPR is low for people with illnesses that need hospital care
- If CPR is not started quickly, brain damage may happen because the brain doesn't have enough oxygen

When CPR is performed, it can cause:

- Broken ribs
- Punctured lungs

If your heart and breathing stop, what would you want?

Choose one by initialing in the space provided or leave it blank. If this section is left blank, CPR will always be attempted.

_____ I always want CPR

_____ I never want CPR given to me. I want to die naturally and be kept comfortable. (If you are certain you do not want CPR, please talk to your physician about a Physician's Order for Life-sustaining Treatment or POLST)

_____ I want CPR unless the doctor treating me states any of the following:

- I have an incurable illness or injury and am likely to die soon, OR
- I am unlikely to return to the acceptable quality of life that I have talked about with my health care agent

Full name:

C. ORGAN DONATION

Becoming an organ and tissue donor when you die can save lives and improve quality of life for other people. There are no age limits on who can donate. Below are some choices to think about.

When I die (choose one by initialing in the space provided):

_____ I want to donate any needed organs or tissues.

_____ I want to donate only these organs or tissues:

_____ I do not want to donate any of my organs or tissues, and I do not want my health care agent to choose donation for me.

_____ I want to donate my whole body to research after I die. As required, I have made plans in advance with:

Organization/Institution Name:

Phone:

Full name:

Making this Document Legal

To make your advance directive legal in California you must sign this form and:

Have 2 witnesses sign the form	OR	**Have it notorized by a notary public**

MY SIGNATURE

My name printed:

My Signature:

Street address:

City/State/Zip:

Phone:

Date:

Full name:

STATEMENT OF WITNESSES

I confirm the following are true:

- I know this person, or this person can prove to me who he/she is
- I am 18 years or older
- I am not his or her health care agent
- I am not his or her health care provider and do not work for the health care provider
- I do not work where he or she lives if it is a nursing home

WITNESS # 1:

Print full name:

Address:

Phone:

Signature:

Date:

WITNESS # 2:

Print full name:

Address:

Phone:

Signature:

Date:

WITNESS #1 OR WITNESS #2 MUST SIGN THE STATEMENT BELOW:

I also confirm the following is true:

- I am not related to the person who signed this form by blood, marriage or adoption
- I will not receive money or property after he/she dies

Print full name:

Signature:

Full name:

Special Witness Requirement
If you are a patient in a skilled nursing facility, the patient advocate or ombudsman must sign the statement below.

STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN:
I declare under penalty of perjury under the laws of California that I am a patient advocate or an ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section 4675 of the California Probate Code.

Signature:

Print full name:

Address:

Date:

NOTARY PUBLIC

STATE OF CALIFORNIA
COUNTY OF SANTA BARBARA

On this _____ day of _____, before me, _____,
Notary Public, personally appeared _____,
who proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument the person, or the entity upon behalf of which the person 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 Public

Next Steps

Now that you have completed your advance directive, you should also take the following steps:

1. MAIL, EMAIL, FAX OR DELIVER IT TO COTTAGE HEALTH

- You'll receive a confirmation the hospital has your advance directive
- If you haven't been a patient at Cottage Health before, the hospital will begin a new record for you

Mailing address:
Rebecca Simonitsch
Advance Care Planning Services
Cottage Health
P.O. Box 689
400 W. Pueblo Street
Santa Barbara, CA 93102

Delivery location:
Front lobby of any Cottage Health hospital:
Santa Barbara Cottage Hospital, 400 W. Pueblo Street, Santa Barbara
Goleta Valley Cottage Hospital, 351 S. Patterson Ave, Goleta
Santa Ynez Valley Cottage Hospital, 2050 Viborg Rd, Solvang

Email: MyCare@sbch.org

Fax: 805-569-8364

2. HAVE THE CONVERSATION:

- Talk about your health care decisions with your health care agent so he or she understands and agrees to this important job
- Share your wishes with family and close friends who might be involved if you are very sick or injured. When they understand what you want for health care, it can make a difficult situation easier for them
- Speak with your doctor so he or she knows what types of health care you want to receive

3. GIVE COPIES TO:

- Your health care agent
- Your family and close friends
- Your primary care doctor and any specialists you see
- Your attorney
- Yourself and keep it in a location where you can easily find it

4. TAKE A COPY WITH YOU:

- When you will be away for a long time, such as taking a trip, studying abroad, or being deployed overseas
- If you go to a hospital, nursing home, or rehabilitation center and have it put in your medical record

5. REVIEW IT REGULARLY TO BE SURE IT'S CURRENT. HELPFUL TIMES INCLUDE:

- Your annual physical
- When your health changes
- When you have a new doctor

6. CHANGE YOUR ADVANCE DIRECTIVE ANYTIME:

- Talk with your doctor
- Send, email, or bring an updated copy to Cottage Health
- Give your health care agent, family, and close friends an updated copy and explain the changes
- Destroy old copies so no one gets confused

Copies of this document have been given to:

☐ **MY FIRST HEALTH CARE AGENT:**

Full name:

Phone:

☐ **MY SECOND HEALTH CARE AGENT:**

Full name:

Phone:

☐ **MY THIRD HEALTH CARE AGENT:**

Full name:

Phone:

☐ **HEALTH CARE PROVIDER/CLINIC:**

Name:

Phone:

OTHERS:

☐ Hospital:

Phone:

☐ Attorney:

Phone:

☐ Name:

Phone:

☐ Name:

Phone:

This advance directive is in compliance with the California Probate Code 4671-4675.

This information is not intended to diagnose health problems or to take the place of medical advice or care you receive from your physician or other health care professional. If you have persistent health problems, or if you have additional questions, please consult with your doctor.