(Optional. Add additional sheets if needed.)

Your Name: ______________________ Print Your Full Name ___/___/___ Date of Birth ___/___/___ Date

Part **2.** **Individual Instructions (Continued)** (You may modify or strike through anything with which you don't agree. Initial & date any modifications.)

E. What Is Important To Me: The things that I value and that make life worth living to me are:
(Examples: gardening, walking my pet, shopping, participating in family gatherings, attending church or temple)

☐ I have attached ________ additional sheet(s)

My thoughts about when I would not want my life prolonged by medical treatment:
(Examples: if not able to communicate, if not able to enjoy eating)

☐ I have attached ________ additional sheet(s)

Witnesses: Choose Either Option 1 or 2, Not Both.

Important: Witnesses cannot be your health care agent, a healthcare provider or an employee of a healthcare facility. One witness cannot be a relative or have inheritance rights.

Option 1: Witnesses

I (Witness 1) declare that the person completing this advance health care directive is personally known to me, that she/he signed or acknowledged this power of attorney in my presence and appears to be of sound mind and under no undue influence. I am not related by blood, marriage, or adoption, and to the best of my knowledge I am not entitled to any part of her/his estate. I am not the person appointed as agent by this document, and I am not a healthcare provider, nor an employee of a healthcare provider or facility.

Witness #1 Print Name | Witness Signature | Date

Street Address | City | State | Zip

I (Witness 2) declare that the person completing this advance health care directive is personally known to me, that she/he signed or acknowledged this power of attorney in my presence and appears to be of sound mind and under no undue influence. I am not the person appointed as agent by this document, and I am not a healthcare provider, nor an employee of a healthcare provider or facility.

Witness #1 Print Name | Witness Signature | Date

Street Address | City | State | Zip

Option 2: Notary Public

State of Hawaii, (City and) County of ______________ } SS.

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 ____-page Hawaii Advance Health Care Directive dated on ____________, in the ____________ Judicial Circuit of the State of Hawaii, and acknowledged that he/she executed the same as his/her free act and deed.

____
Signature of Notary Public

My Commission Expires: ______________

A copy has the same effect as the original. Developed by the **Executive Office on Aging, Kokua Mau** and **Navian Hawaii**.

Revised December 2015

Please Place Notary Seal or Stamp Above

0919-5000

HOSPICE HAWAI'I *is now*

Navian

HOSPICE HAWAII

care for every life journey

Plain speaking in reference to an

Advance Health Care Directive

#96290

#93802

NavianHawaii.org

An **Advance Health Care Directive** is a personal statement about one's future medical decisions that states our desires and wishes when we are unable to speak for ourselves. Generally speaking, family members will not have to guess or argue over our wishes because we have placed our decisions in writing and shared them with those who need to know.

Why an Advance Health Care Directive?

As medical technology advances, it is possible for persons with little or no hope of recovery from a terminal condition to have their life prolonged for months or even years. Everybody needs to consider what type of care they might want should an illness occur. It is important to discuss and decide about these care choices, while we still can. Without an Advance Health Care Directive, families may not be able to choose the care desired, and the doctor may not be able to honor wishes for end-of-life care.

What do I need to put in my Advance Health Care Directive?

- You need to make a choice about whether or not to prolong your life through medical interventions.
- You need to decide about the use of surgically placed tubes to give artificial food and fluids to your stomach if you cannot swallow.
- You need to decide about the use of pain medicine.
- You need to appoint a person and an alternate to make decisions for you if you are not able to decide for yourself. This surrogate (or agent) will have the right to accept or refuse any type of medical care, choose doctors and view medical records, unless you place limits on their authority.

How can I ensure that my Advance Health Care Directive is honored?

Copies should be shared with people who will be involved in your care and in decision making. Your doctors should make your **Advance Health Care Directive** part of your medical records.

If you don't have an Advance Health Care Directives on file or readily accessible, it is possible that your doctor will not know what your wishes are for end-of-life care.

INSTRUCTIONS FOR

Advance Health Care Directive

Complete parts 1 and 2 on the Advance Health Care Directive Form. Pages may be added and changes made. An attorney is not needed to complete this form.

Part 1. *Health Care Power of Attorney*

Select one or more persons to be your agent to make health care decisions if you are unable. The person appointed can be a spouse, adult child, friend or any other trusted person. Your agent cannot be an owner or employee of a healthcare facility unless they are related.

Ask two witnesses to sign and date the form. Both must be people you know. They cannot be healthcare providers (ie. - doctor, nurse or social worker, employees of a healthcare facility, or the person chosen as an agent.) One of the two persons cannot be related to you or have inheritance rights.

Or if you do not have two witnesses, your Advance Health Care Directive must be notarized.

Part 2. *Individual Instruction*

Instructions may be given to your doctor and others about any aspect of your health care. There will be choices to be made. Check only one box in each category and cross out all which do not apply.

When you have completed your Advance Health Care Directive

Be sure to have it witnessed or notarized and inform your family, friends, and doctors that you have done this. Give copies of your Advance Health Care Directive to your healthcare agent, doctors, and others who might be involved in your care. Keep a copy in an easy to find place in your home.

Share and discuss your Advanced Health Care Directive with your doctor, loved ones and agent.

Download the Advance Health Care Directive Form at **NavianHawaii.org**

Hawaii Advance Health Care Directive

My name is: ______ Last ______ First ______ Middle Initial ______ Date of Birth __/__/__ Date __/__/__

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	Relationship of individual designated as health care agent		
Street Address	City	State	Zip
Home Phone	Cell 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	Relationship of individual designated as alternate health care agent		
Street Address	City	State	Zip
Home Phone	Cell Phone	E-mail	

Agent's Authority And Obligation:
My healthcare agent should make decisions as I have instructed in Part 2 of this form or as I may otherwise provide orally or in writing. If there are decisions for which I have not provided instructions, I want my agent to make such decisions as I would have chosen to do, basing them on my values, goals, and preferences rather than those of my agent. If a guardian of my person needs to be appointed for me by a court, I nominate my agent.

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. I can revoke this authority at any time as long as I am mentally capacitated.

Part 2. Individual Instructions (You may modify or strike through anything with which you don't agree. Initial & date any modifications.)

A. End-of-life Decisions

- If I have an incurable and irreversible condition that will result in my death within a relatively short time, OR
- If I have lost the ability to communicate my wishes regarding my health care and it is unlikely that I will ever recover that ability, OR
- If the likely risks and burdens of treatment would outweigh the expected benefits.

Then I direct that my healthcare providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below: Check only one of the following boxes. You may also initial your selection.

☐ I want to stop or withhold medical treatment that would prolong my life.

OR

☐ I want medical treatment that would prolong my life as long as possible within the limits of generally accepted health care standards.

B. Artificial Nutrition And Hydration - Food And Fluids:
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 under all circumstances as long as it is within the limits of generally accepted healthcare standards.

C. Relief From Pain:
☐ If I mark this box, I choose treatment to alleviate pain or discomfort even if it might hasten my death.

D. Other:
☐ If I mark this box, the additional instructions or information I have attached are to be incorporated into my care. (Sign and date each added page and attach to this form.)

Initial & Date