

## **SOME QUESTIONS FOR YOU TO CONSIDER BEFORE SIGNING AN ADVANCE HEALTH CARE DIRECTIVE**

1. **THE AGENT YOU CHOOSE:** The most important decision for the Principal (one signing the health care directive) is to choose a trustworthy, reliable Agent. No matter what is written in a power of attorney, the Agent can effectively nullify everything you order the Agent to do under the health care powers. The biggest area of contention is found in Part 2, INSTRUCTIONS FOR HEALTH CARE, on Page 4 of the Statutory Form. It appears relatively simple for an Agent to follow directions. However, there are all sorts of reasons why an Agent might not want to follow your directions.

2. **SOME QUESTIONS TO CONSIDER BEFORE SIGNING AN ADVANCE HEALTH CARE DIRECTIVE:** What will be really important to you if you are in really serious trouble with your health? What will be important to you when you are dying (e.g., family members present, no pain, physical comfort)?

How do you feel about the use of life-sustaining measures in the face of:

- a. Terminal illness.
- b. Permanent coma.
- c. Chronic illness or disability(Alzheimer's disease).
- d. Do you have strong feelings about particular medical procedures (e.g., CPR, artificial nutrition and hydration, antibiotics, kidney dialysis, chemotherapy, or radiation therapy)?
- e. Would your feelings about these procedures change depending on your health condition and prognosis?
- f. How do you feel about participating in clinical research after you have lost capacity?
- g. Do you want to consider financial matters when treatment decisions are made?
- h. How do you feel about placement in a nursing home if your condition warrants it?
- i. Do you wish to participate or share in making decisions about your health care treatment?
- j. What limitation to your physical and mental health would affect your participation in your health care decisions and treatments?
- k. Would you always want to know the truth about your condition even if it is very grim?
- l. Would you want to be an organ donor at the time of your death?
- m. Would you wish to be buried or cremated at time of your death?
- n. Do you wish to make a personal statement about any health care matters not covered above?
- o. What else do you want to say about the care of your physical being once someone else must care for you?

Miscellaneous Comments: \_\_\_\_\_

(add separate sheet(s) with signatures or initials thereon to indicate authenticity)

**(The following materials are not necessarily relevant in most cases. These sample forms serve to illustrate some issues that may arise on the later use of the Advance Health Care Directive by an agent. If someone later challenges the agent on making a health care decision on your behalf, these forms are very helpful. In the first form below, you are authorizing the doctor to make a statement that he can disclose the information about your physical and mental condition.)**

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

To permit the medical doctor named below to make statements about my medical or mental conditions on or about the date of my document(s) to be validated, I hereby waive any confidentiality granted under the Health Insurance Portability and Accountability Act (HIPAA) and agree that the physician signing below is specifically granted the right to give the opinions on my health conditions.

Dated: \_\_\_\_\_ Signed: \_\_\_\_\_, MD  
Print Name Here: \_\_\_\_\_

.....  
The sample form below records in writing what the physician found about your condition.  
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PHYSICIAN STATEMENT REGARDING CAPACITY

I, \_\_\_\_\_, MD, being a licensed physician in the State of California, state that I have examined \_\_\_\_\_ and as of the date of this statement believe that the person has the capacity to execute an Advance Health Care Directive in that the person understands the following:

- (a) his or her diagnosed condition;
- (b) significant benefits, risks, and alternatives to various treatment options;
- (c) the consequences of not accepting recommended treatment.

I further believe that the above-named persons can make and communicate a health care decision and understands the consequences of naming someone else to make health care decisions under a power of attorney.

Dated: \_\_\_\_\_ (Signed) \_\_\_\_\_  
(Print Name: \_\_\_\_\_, MD