Advance Care Planning Program
Appointment Information Sheet

At Santa Rosa Community Health Centers, we honor your care preferences, at each stage of life. We especially want to respect your wishes about care you want near the end of life.

We invite you to return for an Advance Care Planning Appointment. Your Care Team will help you understand your care options for different situations you may face, explain all your choices, and give you information about the best ways to document and communicate your wishes about end-of-life care.

Here’s what an Advance Care Planning appointment includes:

- A conversation with your Care Team nurse about your end-of-life wishes
- Documenting your wishes in an Advance Directive or POLST form
- Support for telling family and loved ones about your end-of-life choices
- Information about other places you can get end-of-life care education and help with your decisions in a caring, respectful environment

After your appointment, your end-of-life wishes will be shared with all of your doctors and providers, so that everyone—from the ambulance, to the Emergency Department, to the hospital doctors—will know and respect your choices.

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Advance Care Planning Appointment

With Nurse:  ______________________________________________________

Date: __________________________  Time:  ___________________________

Vista Wing:  ______________________________________________________
Finding Your Way was written by the Center for Healthcare Decisions (CHCD), a private nonprofit organization dedicated to advancing healthcare that reflects the values and priorities of an informed public.

This information is based on CHCD’s 1997 ECHO project, which involved more than 2,000 community members and healthcare professionals in developing recommendations to improve medical care at the end of life. CHCD thanks the many colleagues and community members who assisted in preparing this booklet. Support was provided through grants from Sierra Health Foundation.

The Coalition for Compassionate Care of California is a statewide collaboration of healthcare providers, state agencies and individuals working together to promote high quality, compassionate care toward the end of life.

Order Finding Your Way:
• Online at www.CoalitionCCC.org
• Or call the Coalition for Compassionate Care of California (916) 489-2222

Finding Your Way is also available in Spanish.
Mrs. Lee’s Story, an adaptation for Chinese families, is available in a bi-lingual format.

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Americans are independent; they like to control their own lives. However, they rarely think about the final stage of life and, as a result, often are unprepared to face heart-wrenching decisions. Marilyn Webb suggests in her book *The Good Death: The New American Search to Reshape the End of Life* that while a good death was once a matter of sheer luck, now it “has more to do with the decisions we—and our healthcare providers—make about our medical treatment and terminal care . . .”

Finding Your Way prepares you for making these decisions. You will learn:

- Why you should think about this issue now rather than later.
- How to address the complex issues that you or your family may face.
- What to expect from your doctor and other health professionals.
- How to advocate for compassionate care for yourself or a loved one.

Research shows that people have strong feelings about care at the end of life. They worry about how their decisions will affect their families emotionally and financially. They want to work with their doctors to decide the right treatment. They fear their doctors will stop caring for them when the end is near. They want emotional and spiritual support, as well as good medical care. Most of all, they want to die as peacefully as possible, free from severe pain and suffering.
Most people first deal with end-of-life issues not with their own medical crisis but with the death of a relative or friend.

The Morrison Family

Tim and Nancy Morrison are in their 30s with two young children. Work and their children’s activities fill their days. But a phone call from Tim’s mother gives them pause. She tells them that after a two-year bout with cancer, Tim’s boyhood friend Dave just died. Tim is shaken to learn that Dave stopped his cancer treatment several weeks ago.

Tim couldn’t understand why Dave gave up the fight. He had never been a quitter before, and it was hard for Tim to accept that his friend had stopped the treatment.

Nancy, on the other hand, thought about how sick Dave had been with the cancer treatment. She could imagine that some people, like Dave, would finally decide that it was no longer worth it.

They talked about what each of them might have done in Dave’s position. To their surprise, they discovered they actually had very different views about how they would make this kind of decision.

Nancy and Tim went to bed that night thinking of Dave and his family and wondering, “What if . . . “

Both Tim and Nancy had lost grandparents, but they had never thought about their own deaths until Dave died. His death prompted them to think about and discuss their views about dying. Realizing that one of them might have to be the decision-maker for the other, they talked over their own beliefs about what is important at the end of life.

Why, you might ask, should young, healthy people like Tim and Nancy bother with end-of-life planning when they have no need now?
There are several reasons. First, “advance care planning” allows you to think about important issues when you don’t need to make immediate decisions or aren’t under great emotional stress. It’s also good to know that your loved one understands your wishes should you unexpectedly become unable to speak for yourself. And if you become the decision-maker, you don’t have to guess what your loved one wants; you’re prepared to act based on what you know. Finally, if you and your family have different views, advance care planning can help avoid serious family conflict.

**How to begin advance care planning**

As it did for the Morrisons, the subject often arises when a close friend or relative dies. News coverage of the death of a celebrity, magazine articles or community meetings on the subject may also bring it to your attention. You can begin by considering these questions:

- **What represents a good quality of life to you?**
- **What concerns you most about death or dying?**
- **How would you want to spend the last month of your life?**
- **Some people want everything possible done to delay death. Others don’t want dying to be prolonged. Where do YOU draw the line?**
- **Who should make these decisions for you if you can’t speak for yourself?**

Sharing your views with those important to you is a good way to explore this topic. This also can help you identify the person best able to speak for you if it becomes necessary.

**Next steps**

If you have a doctor, it is helpful to make sure he or she knows your specific views about end-of-life care. You may want to schedule an appointment to talk to your medical caregiver — such as your primary care doctor, nurse practitioner or specialist.
Also, you may want to complete a document called an *advance directive*, such as a Medical Power of Attorney. This allows you to state in writing who will speak for you if you can’t communicate and to indicate your treatment preferences. Or you may complete a Living Will, which states your wishes about life-sustaining measures if you are terminally ill or permanently unconscious. All states have at least one type of legal advance directive. California uses a single type of form, an Advance Health Care Directive.

If you have a serious health condition, you may also find it helpful to talk with your doctor about Physician Orders for Life-Sustaining Treatment (POLST). Available in many states (sometimes under a different name, e.g., MOLST, POST), the POLST form documents your specific wishes for medical treatment.

Completing these documents can help if family members do not know what you want or may not agree on the type of care you should receive. While these documents are useful, talking with those closest to you is also important.

**Advance Care Planning Steps**

- Consider your personal values about quality of life. What makes living meaningful to you?
- Choose someone you trust to speak for you should you become unable to communicate.
- Talk with your decision-maker and other loved ones about your views.
- Talk with your doctor about your views on medical treatment near the end of life.
- Complete an advance directive and/or a POLST (see page 12).

**When facing hard decisions**

Advance care planning is a process rather than a single decision. Most likely you will face a series of choices as your health and personal goals gradually change over time. However, if faced with having to make decisions now—

*Advance care planning is a process rather than a single decision.*
for yourself or a loved one—there are things you can do to make sure the last months, weeks or days of life reflect your or your loved one’s wishes about living and dying.

The Thompkins Family

Ada Thompkins is an 82-year-old retired teacher with three grown children and seven grandchildren. After losing her husband several years ago, Mrs. Thompkins’ physical and mental abilities gradually declined, leaving her in need of increasing help from her children. The Thompkins are a close-knit family with a long tradition of shared activities.

Three years ago, when Mrs. Thompkins suffered a severe stroke that left her unable to move her body or talk, she was placed in a nursing home, where her family visited every day. Hospitalized several times for pneumonia, she now has a permanent feeding tube, is very weak, and no longer recognizes her family.

Mrs. Thompkins has returned to the hospital, where she is receiving intensive treatment for her heart condition. When her oldest son Fred arrives, he worries, “I just don’t know if this is what Mom would have wanted.” For all their closeness, the family has never discussed their personal values about the last months of life. They have never talked about dying.

Situations like this are common. So are the questions they raise: If this were your mother, would you know how she wants to live her last days? If you were Mrs. Thompkins, what would you hope your children would do? Unlike the Morrisons, who started talking about their views on dying as young adults, the Thompkins don’t know their mother’s wishes. Since she can no longer communicate, her family has to imagine what she might want.

When a family makes these kinds of decisions for a loved one, they need to consider several things:
1. **Medical condition and chances for improvement**

It is sometimes difficult for people to accept that a loved one is at the last stage of life, especially since doctors usually can’t predict how long someone will live. The subject of dying is often avoided for fear that it means “giving up.” Yet, when family members are helped to face what lies ahead, they are better able to seek the care best suited for their loved one. The first step is understanding the patient’s medical condition now and what may come later.

If you are the decision-maker for a loved one like Mrs. Thompkins, you will want to ask the doctor:

- Is it still possible to cure her disease or illness?
- If not, what are her chances of at least improving?
- Given her current condition, what do you expect in the next few weeks? In the next few months?
- Are other medical problems likely to arise?

2. **Treatment options**

In general, there are three goals of treatment for someone in the last phase of life:

- Restoring the person to a healthier state.
- Supporting the person to maintain his or her current level of health.
- Providing comfort without trying to prolong life.

All of us hope that medical science will provide cures, and if not, at least help improve health. Yet with severe illness, terrible accident, or advanced age, it may no longer be possible to make a person well. At that point, continued treatment may support life and keep the person comfortable.

But for some patients the treatments or machines that support life also may cause or prolong suffering. When that happens, life-sustaining measures—such as breathing machines, CPR,
artificial nutrition, IV fluids and antibiotics—can be stopped or not used at all. Palliative care then becomes the focus. This approach can help control pain and other symptoms while addressing the emotional and spiritual needs of the patient and family.

Palliative care should always be offered to those who are seriously ill or near the end of life. Hospice programs specialize in palliative care, but other healthcare teams often provide it in hospitals, nursing homes or at home. If your doctor doesn’t discuss palliative care, be sure to ask about these services.

Questions to ask about your loved one’s treatment options:

- *Is there any treatment that will help regain her health? Are there side effects?*
- *Is there treatment to prolong her life? What kind of life will she have?*
- *What will be provided if we decide to focus on comfort only?*
- *Is palliative care or hospice available? What services will be provided?*
- *Would it be helpful to complete a POLST on her behalf?*
- *What other help is available for the family at this time?*

3. **Quality of life**

The person’s quality of life is usually the most important thing to consider at this time. While the patient is the best one to decide his/her own quality of life, sometimes families need to do this for their loved one, as in the case of Mrs. Thompkins. Although the Thompkins don’t know their mother’s views or wishes, they can begin by thinking about how she might feel about her quality of life now.
Questions to consider:

- Is she able to enjoy the things that bring her pleasure?
- How much discomfort is she now experiencing?
- Is she able to talk or respond to others, especially family members?
- Does her medical treatment fit with her cultural values and religious beliefs?
- If she could talk to you about her care, what would she say?

When the time comes, judging a loved one’s quality of life can be difficult. Even if you believe your loved one would not want to continue having life-sustaining measures, it can be hard to let go. You may feel guilty that you have not done everything you could. You may worry about money problems or unsettled family issues. Talking with a spiritual leader or a counselor can help you with these concerns.

Involving others in the process

You and your family do not have to face these choices alone. Your doctor can give you medical information and advice. Nurses, social workers, chaplains, support groups and your faith community also can help with emotional support or the day-to-day problems of caring for someone who is dying—whether in a hospital, nursing home or at home. Talking to these caregivers as early as possible can help you when making difficult decisions.

Sometimes, you may not agree with the doctor about the best course of action. If this occurs, speak openly about your concerns. If you are still unsure, you may want to seek another doctor’s opinion, ask for a care team meeting, or speak with a patient assistance employee from your hospital or health plan. In some cases, hospital ethics committees—with doctors, nurses, chaplains, community members and others—can help you and your family with these concerns and help solve conflicts.
If your loved one is very ill, many doctors may be involved. This can make it hard to stay well informed and talk clearly with all of them. If this happens, you need to be forthright—set up meetings with the doctors, write down your questions in advance, keep notes, and be available when changes occur. Nurses can play an important role in helping you. If there are many family members, you might also consider naming one as the main contact person to talk with doctors.

All those involved in caring for a person who is dying—family members, doctors, nurses, social workers, clergy and other support staff—have a role in making sure that end-of-life care is compassionate.

The checklists on the following pages tell you what you should expect from your doctor, as well as those actions you should take yourself.

Whether you are in the early stages of planning like the Morrisons, faced with decisions for a family member like the Thompkins, or somewhere in between, you can help to shape the last stage of life. Advance care planning, good communication, and shared decision-making are important ways to obtain end-of-life care that will bring peace of mind to you and your family.

“Modern medicine may have made dying harder, but it has also given us the gift of time—the time to prepare, the time to heal family wounds, the time to bring psychological and spiritual closure. If we can take advantage of it, it has given us something unique in history: the time to tie up loose ends and orchestrate a death that is good.”

Marilyn Webb
The Good Death
Checklist

How Your Doctor Should Work With You

Your doctor should:

**Discuss advance care planning.**
- ✓ Give you time to talk about your concerns.
- ✓ Ask about and respect your values and decisions.
- ✓ When appropriate, document your wishes in a POLST.

**Provide clear and complete information.**
- ✓ Make sure that you understand important information.
- ✓ Discuss future decisions, giving you time to consider and plan.
- ✓ Discuss treatment options and goals, including palliative care.

**Encourage decisions that all can accept.**
- ✓ Provide time for you to consider different treatments.
- ✓ Involve you and your family in developing the plan of care.
- ✓ Encourage discussion with others if there is disagreement.

**Assist you in handling non-medical concerns.**
- ✓ Involve social services for emotional and practical support, including financial concerns.
- ✓ Enlist help of a chaplain or other resources to offer spiritual support.

**Provide palliative care to you and your family.**
- ✓ Make sure you and your family know what to expect during the dying process.
- ✓ Consider both your own and your family’s needs as part of palliative care.
- ✓ Ensure pain relief and symptom control.
- ✓ Discuss hospice services.
Checklist

Steps for Finding Your Way

When doing advance care planning, you should:

✔ Consider your own views about the last stage of life.
✔ Discuss these views with your family or close friends.
✔ Pick a substitute decision-maker who knows you well and is able and willing to speak for you if you can’t communicate. If you have no decision-maker, write down your wishes for care in an advance directive.
✔ Discuss your views with your doctors.
✔ Complete an advance directive form and give copies to your decision-maker and doctor.
✔ From time to time talk about this with family or friends, since personal views may change.

When facing difficult decisions, you should:

✔ Recognize that the dying process is complex. Unexpected medical, emotional, spiritual and practical issues may arise.
✔ If there is an advance directive or a POLST, make sure it is in the medical record.
✔ Ask your doctor to discuss treatment options and goals for this stage of life and record your wishes in a POLST, making sure your advance directive is consistent.
✔ If the doctor’s views don’t agree with yours, talk to the doctor and try to work out differences.
✔ Realize that treatments and goals may change as the illness progresses and you may stop treatments if they no longer meet your goals.
✔ Be aware that intense feelings and family problems can make it hard to talk about these issues.
✔ If you are a spokesperson, make decisions based on your loved one’s views, whether you fully agree or not.
✔ Make use of resources such as hospital chaplains, social workers and ethics committees.
Advance Directives

All states recognize at least one type of advance directive. While the laws of each state may vary on wording and restrictions, there are two main types of directives.

- **Medical Power of Attorney**—Also known as a Power of Attorney for Health Care (or Health Care Proxy), lets you choose someone to make your healthcare decisions if you cannot.
- **Living Will**—Tells your doctors how you want to be treated if you become permanently unconscious or suffer from a terminal illness.

California uses a single type of form, an Advance Health Care Directive.

For more information or to obtain an advance directive form:

- Call your hospital’s social services, patient education, admissions or chaplaincy department.
- Call the National Hospice and Palliative Care Organization Helpline at 1-800-658-8898.
- Visit the Coalition for Compassionate Care of California website for more resources at www.CoalitionCCC.org

**POLST (Physician Orders for Life-Sustaining Treatment)**

POLST is a form used in many states. It records the types of medical treatment that a patient wishes to receive towards the end of life, including whether to:

- Attempt cardiopulmonary resuscitation (CPR),
- Give antibiotics and IV fluids,
- Use a ventilator to help with breathing, and
- Provide artificial nutrition by tube.

Signed by a medical professional, POLST guides care in the hospital, nursing home or at home. In many states, both the doctor and the patient must sign the POLST.

The POLST form complements but is not intended to replace an advance directive. While POLST is designed for seriously ill individuals, an advance directive that appoints a spokesperson is recommended for all adults, regardless of their health status.
To learn more or find out if POLST is available in your state, talk with your doctor or visit: www.polst.org. In California, visit: www.capolst.org.

**Palliative Care Services**

Many hospitals have palliative care programs that serve people with serious illnesses and their families. Palliative care addresses medical, emotional and spiritual needs and can be provided in hospitals, nursing homes or at home. The focus is on the whole person and their quality of life, rather than looking only at their disease and how to treat it. To learn more, ask your doctor or hospital about available services.

**Hospice Programs**

Most communities have hospice programs that provide medical services, emotional support and spiritual resources for dying persons and their families, and support for grieving family members. Medicare and most Medicaid programs and health plans pay for hospice services. To learn more, ask your doctor or hospital for the name of a local hospice. Or contact the National Hospice and Palliative Care Organization Helpline (1-800-658-8898) or website (www.nhpco.org) for location of hospices near you.

**Faith Communities**

Communities of faith offer support to dying persons and their families through health ministry programs, faith community nurses, and clergy trained in pastoral care. Many religious communities also study end-of-life issues, addressing decisions such as stopping medical treatment or using artificial nutrition. Ask your faith leader for more information.

**Health Plans**

If you belong to a health plan, contact its health education department for classes or materials, including printed information and videos on topics such as decision-making and advance directive forms.
California Advance Health Care Directive

This form lets you have a say about how you want to be treated if you get very sick.

This form has 3 parts. It lets you:

Part 1: Choose a health care agent.
A health care agent is a person who can make medical decisions for you if you are too sick to make them yourself.

Part 2: Make your own health care choices.
This form lets you choose the kind of health care you want.
This way, those who care for you will not have to guess what you want if you are too sick to tell them yourself.

Part 3: Sign the form.
It must be signed before it can be used.

You can fill out Part 1, Part 2, or both. Fill out only the parts you want.
Always sign the form in Part 3.

Go to the next page
If you only want a health care agent, go to Part 1 on page 3.

If you only want to make your own health care choices, go to Part 2 on page 6.

If you want both, then fill out Part 1 and Part 2.

Always sign the form in Part 3 on page 9.

What do I do with the form after I fill it out?

Share the form with those who care for you:
- doctors
- nurses
- social workers
- family
- friends

What if I change my mind?
- Change the form.
- Tell those that care for you about your changes.

What if I have questions about the form?
- Bring it to your doctors, nurses, social workers, family or friends to answer your questions.

What if I want to make health care choices that are not on this form?
- Write your choices on a piece of paper.
- Keep the paper with this form.
- Share your choices with those who care for you.
PART 1 Choose your health care agent

The person who can make medical decisions for you if you are too sick to make them yourself.

Whom should I choose to be my health care agent?

A family member or friend who:

- is at least 18 years old
- knows you well
- can be there for you when you need them
- you trust to do what is best for you
- can tell your doctors about the decisions you made on this form

Your agent cannot be your doctor or someone who works at your hospital or clinic, unless they are a family member.

What will happen if I do not choose a health care agent?

If you are too sick to make your own decisions, your doctors will ask your closest family members to make decisions for you.

If you want your agent to be someone other than family, you must write his or her name on this form.

What kind of decisions can my health care agent make?

Agree to, say no to, change, stop or choose:

- doctors, nurses, social workers
- hospitals or clinics
- medications or tests
- what happens to your body and organs after you die

Go to the next page
Life support treatments - medical care to try to help you live longer

- CPR or cardiopulmonary resuscitation
  
  cardio = heart    pulmonary = lungs    resuscitation = to bring back

  This may involve:
  
  - pressing hard on your chest to keep your blood pumping
  - electrical shocks to jump start your heart
  - medicines in your veins

- Breathing machine or ventilator
  
  The machine pumps air into your lungs and breathes for you.
  
  You are not able to talk when you are on the machine.

- Dialysis
  
  A machine that cleans your blood if your kidneys stop working.

- Feeding Tube
  
  A tube used to feed you if you cannot swallow. The tube is placed down your throat into your stomach. It can also be placed by surgery.

- Blood transfusions
  
  To put blood in your veins.

- Surgery

- Medicines

End of life care - if you might die soon your health care agent can:

- call in a spiritual leader
- decide if you die at home or in the hospital

Show your health care agent this form.

Tell your agent what kind of medical care you want.
# Part 1: Choose your health care agent

## Your Health Care Agent

- **I want this person to make my medical decisions.**

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- **If the first person cannot do it, then I want this person to make my medical decisions.**

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- **Put an X next to the sentence you agree with.**

- My health care agent can make decisions for me **now**.

- My health care agent will make decisions for me **only** after I cannot make my own decisions.

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To make your own health care choices **go to part 2 on the next page.**

To sign this form **go to part 3 on page 9.**
PART 2  Make your own health care choices

Write down your choices so those who care for you will not have to guess.

- Think about what makes your life worth living.
  Put an X next to all the sentences you most agree with.

  - My life is **only** worth living if I can:
    - talk to family or friends
    - wake up from a coma
    - feed, bathe, or take care of myself
    - be free from pain
    - live without being hooked up to machines
    - I am not sure

  - My life is always worth living no matter how sick I am

- If I am dying, it is important for me to be:

  - at home
  - in the hospital
  - I am not sure

- Is religion or spirituality important to you?

  - yes
  - no

- What should your doctors know about your religion or spirituality?

  ____________________________________________________________

If you are sick, your doctors and nurses will always try to keep you comfortable and free from pain.

Go to the next page
Part 2: Make your own health care choices

Life support treatments are used to try to keep you alive. These can be CPR, a breathing machine, feeding tubes, dialysis, blood transfusions, or medicine.

Put an X next to the sentences you most agree with.
Please read this whole page before you make your choices.

If I am so sick that I may die soon:

- Try all life support treatments that my doctors think might help.
  If the treatments do not work and there is little hope of getting better, I want to stay on life support machines.

- Try all life support treatments that my doctors think might help.
  If the treatments do not work and there is little hope of getting better, I do not want to stay on life support machines.

- Try all life support treatments that my doctors think might help but not these treatments. Mark what you do not want.
  - CPR
  - feeding tube
  - dialysis
  - blood transfusion
  - breathing machine
  - medicine
  - other treatments _____________________________________

- I do not want any life support treatments.

- I want my health care agent to decide for me.

- I am not sure.
Part 2: Make your own health care choices

Your doctors may ask about organ donation and autopsy after you die. Please tell us your wishes.

Put an X next to the sentences you most agree with

- Donating (giving) your organs can help save lives.
  - I want to donate my organs.
    - Which organs do you want to donate?
      - any organs
      - only ________________________________
  - I do not want to donate my organs.
  - I want my health care agent to decide.
  - I am not sure.

- An autopsy can be done after death to find out why someone died. It is done by surgery. It can take a few days.
  - I want an autopsy.
  - I do not want an autopsy.
  - I may want an autopsy if there are questions about my death.
  - I want my health care agent to decide.
  - I am not sure.

- What should your doctors know about how you want your body to be treated after you die?

Go to Part 3 on the next page to sign this form
PART 3  Sign the form

Before this form can be used, you must:

• sign this form
• have two witnesses sign the form

If you do not have witnesses, you need a notary public. A notary public’s job is to make sure it is you signing the form.

Sign your name and write the date.

/ / 

sign your name date

print your first name print your last name

address city state zip code

Your witnesses must:

• be over 18 years of age
• know you
• see you sign this form

Your witnesses cannot:

• be your health care agent
• be your health care provider
• work for your health care provider
• work at the place that you live (if you live in a nursing home go to page 12)

Also, one witness cannot:

• be related to you in any way
• benefit financially (get any money or property) after you die

Witnesses need to sign their names on the next page.

If you do not have witnesses, take this form to a notary public and have them sign on page 11.
Part 3: Sign the form

Have your witnesses sign their names and write the date

By signing, I promise that ________________, signed this form while I watched. They were thinking clearly and were not forced to sign it.

I also promise that:

- I know them or they could prove who they are
- I am 18 years or older
- I am not their health care agent
- I am not their health care provider
- I do not work for their health care provider
- I do not work where they live

One witness must also promise that:
- I am not related to them by blood, marriage, or adoption
- I will not benefit financially (get any money or property) after they die

Witness #1

________________________________________ / /  
sign your name                        date

print your first name                  print your last name

_________________________       ____________________
address                            city                  state                  zip code

Witness #2

________________________________________ / /  
sign your name                        date

print your first name                  print your last name

_________________________       ____________________
address                            city                  state                  zip code

You are now done with this form.

Share this form with your doctors, nurses, social workers, friends, and your family.

Talk with them about your choices.
NOTARY PUBLIC

- Take this form to a notary public ONLY if two witnesses have not signed this form.
- Bring photo I.D. (driver’s license, passport, etc.)

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Bring photo I.D. (driver’s license, passport, etc.)

CERTIFICATE OF ACKNOWLEDGEMENT OF NOTARY PUBLIC

State of California

County of ____________

On ____________ before me, ______________________________, personally
appeared ______________________________

Date

Here insert name and title of the officer

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.

Signature ______________________________

Signature of Notary Public ______________________________

Description of Attached Document

Title or Type of document: __________________

Date: _______ Number of pages: ________

Capacity(ies) Claimed by Signer(s)

Signer’s Name: ____________________________

☐ Individual

☐ Guardian or conservator

☐ Other ____________________________

RIGHT THUMBPRINT OF SIGNER

Top of thumb here (Notary Seal)

You are now done with this form.

Share this form with your doctors, nurses, social workers, friends, and your family.

Talk with them about your choices.
For California Nursing Home Residents ONLY

- Give this form to your nursing home director only if you live in a nursing home.

- California law requires nursing home residents to have the nursing home ombudsman as a witness of advance directives.

STATEMENT OF THE 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.”

/ / 
sign your name date

print your first name print your last name

address city state zip code

This advance directive is in compliance with the California Probate Code, Section 4671-4675. http://www.leginfo.ca.gov/calaw.html

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2011 California POLST Form

Effective April 1, 2011

In order to maintain continuity throughout California, please follow these instructions:

*** Copy or print POLST form on 65# Cover Ultra Pink card stock. ***

Mohawk BriteHue Ultra Pink card stock is available online and at some retailers, such as FedEx/Kinko’s.

Ultra Pink paper is used to distinguish the form from other forms in the patient’s record; however, the form will be honored on any color paper. Faxed copies and photocopies are also valid POLST forms.
Physician Orders for Life-Sustaining Treatment (POLST)

First follow these orders, then contact physician. This is a Physician Order Sheet based on the person’s current medical condition and wishes. Any section not completed implies full treatment for that section. A copy of the signed POLST form is legal and valid. POLST complements an Advance Directive and is not intended to replace that document. Everyone shall be treated with dignity and respect.

**A**
**CARDIOPULMONARY RESUSCITATION (CPR):** *If person has no pulse and is not breathing.*
- [ ] Attempt Resuscitation/CPR (Selecting CPR in Section A requires selecting Full Treatment in Section B)
- [ ] Do Not Attempt Resuscitation/DNR (Allow Natural Death)

**B**
**MEDICAL INTERVENTIONS:** *If person has pulse and/or is breathing.*
- [ ] Comfort Measures Only Relieve pain and suffering through the use of medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. *Transfer to hospital only if comfort needs cannot be met in current location.*
- [ ] Limited Additional Interventions In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.
- [ ] Transfer to hospital only if comfort needs cannot be met in current location.
- [ ] Full Treatment In addition to care described in Comfort Measures Only and Limited Additional Interventions, use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion as indicated. *Transfer to hospital if indicated. Includes intensive care.*

Additional Orders: __________________________________________________________

**C**
**ARTIFICIALLY ADMINISTERED NUTRITION:** *Offer food by mouth if feasible and desired.*
- [ ] No artificial means of nutrition, including feeding tubes.
- [ ] Trial period of artificial nutrition, including feeding tubes.
- [ ] Long-term artificial nutrition, including feeding tubes.

Additional Orders: __________________________________________________________

**D**
**INFORMATION AND SIGNATURES:**
Discuss with:
- [ ] Patient (Patient Has Capacity)
- [ ] Legally Recognized Decisionmaker
- [ ] Advance Directive dated ________ available and reviewed → Health Care Agent if named in Advance Directive:
  - Name: _________________________________________
  - Phone: _________________________________________
- [ ] Advance Directive not available
- [ ] No Advance Directive

**Signature of Physician**
My signature below indicates to the best of my knowledge that these orders are consistent with the person’s medical condition and preferences.

Print Physician Name: ____________________________
Physician Phone Number: ____________________________
Physician License Number: ____________________________

Physician Signature: (required)
Date: ____________________________

**Signature of Patient or Legally Recognized Decisionmaker**
By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Print Name: ____________________________
Relationship: (write self if patient)
Date: ____________________________

Signature: (required)
Date: ____________________________

Address: ____________________________
Daytime Phone Number: ____________________________
Evening Phone Number: ____________________________

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED
### Directions for Health Care Provider

#### Completing POLST
- Completing a POLST form is voluntary. California law requires that a POLST form be followed by health care providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician who will issue appropriate orders.
- POLST does not replace the Advance Directive. When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts.
- POLST must be completed by a health care provider based on patient preferences and medical indications.
- A legally recognized decisionmaker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient’s physician believes best knows what is in the patient’s best interest and will make decisions in accordance with the patient’s expressed wishes and values to the extent known.
- POLST must be signed by a physician and the patient or decisionmaker to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.
- Certain medical conditions or treatments may prohibit a person from residing in a residential care facility for the elderly.
- If a translated form is used with patient or decisionmaker, attach it to the signed English POLST form.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. A copy should be retained in patient’s medical record, on Ultra Pink paper when possible.

#### Using POLST
- Any incomplete section of POLST implies full treatment for that section.

**Section A:**
- If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a person who has chosen “Do Not Attempt Resuscitation.”

**Section B:**
- When comfort cannot be achieved in the current setting, the person, including someone with “Comfort Measures Only,” should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- IV antibiotics and hydration generally are not “Comfort Measures.”
- Treatment of dehydration prolongs life. If person desires IV fluids, indicate “Limited Interventions” or “Full Treatment.”
- Depending on local EMS protocol, “Additional Orders” written in Section B may not be implemented by EMS personnel.

#### Reviewing POLST
It is recommended that POLST be reviewed periodically. Review is recommended when:
- The person is transferred from one care setting or care level to another, or
- There is a substantial change in the person’s health status, or
- The person’s treatment preferences change.

#### Modifying and Voiding POLST
- A patient with capacity can, at any time, request alternative treatment.
- A patient with capacity can, at any time, revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing “VOID” in large letters, and signing and dating this line.
- A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician, based on the known desires of the individual or, if unknown, the individual’s best interests.

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This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force. For more information or a copy of the form, visit [www.caPOLST.org](http://www.caPOLST.org).