Monterey County Behavioral Health
Policy and Procedure

Policy Number	471
Policy Title	Advance Health Care Directives
References	TITLE 42, SECTIONS 438.6(h)(2)(i), 422.128(B)(1)(i)(F) and 417.436(d)(1)(iv), 1395cc(f) and 1396a(w) NATIVIDAD MEDICAL CENTER POLICY 1:0900 ADVANCE DIRECTIVES
Form	ATTACHMENT 1 – ADVANCE HEALTH CARE DIRECTIVE [ENGLISH (5-15) AND SPANISH (16-24) ATTACHMENT 2 - YOUR RIGHTS TO MAKE DECISIONS ABOUT MEDICAL TREATMENT PAMPHLET (25-27) ATTACHMENT 3 – ADVANCE DIRECTIVE ADMISSION STATEMENT FOR NATIVIDAD MEDICAL CENTER [ENGLISH (28) AND SPANISH (29)] ATTACHMENT 4 – WELCOME TO NATIVIDAD MEDICAL CENTER PAMPHLET (30-34) ATTACHMENT 5 – ADVANCE HEALTH CARE DIRECTIVE (ENGLISH) 8610-9038 NMC (35-49) ATTACHMENT 6 - DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS (ENGLISH) © CALIFORNIA MEDICAL ASSOCIATION – NMC (50-54) ATTACHMENT 7 – DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS (SPANISH) © CALIFORNIA MEDICAL ASSOCIATION – NMC (55-57) ATTACHMENT 8 – ADVANCE DIRECTIVE STATEMENT (58-59)
Effective	MARCH 1, 2009

POLICY

The Monterey County Behavioral Health Division (MCBHD) supports The Patient Self-Determination Act of 1990 (PSDA) which requires hospitals, skilled nursing facilities, home health, personal care agencies, and hospice programs maintain written policies and procedures to assure that every adult (or emancipated minor) receiving medical care by or through the organization is provided written information at the time of every admission concerning their individual right under state law to make decisions regarding his/her medical care. That includes

the right to accept or refuse treatment and the right to formulate an advanced directive by individual health care instruction or a power of attorney [Probate Code Section 4629 (www.dmh.ca.gov/DMHDocs/docs/letters04/04-08_Encl_2.pdf - 2007-10-15)] for health care (any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect their physical or mental condition (Probate Code Section 4615). It should be presented in a reasonably clear manner.

PROCEDURE

1. MCBHD (Inpatient and/or Outpatient) will provide written information to adult consumers (or emancipated minors) of an individual's rights under state law to make decisions regarding medical care, including the right to accept or refuse treatment and the right to formulate advance directives. Parents/legal caretakers of minor children who receive services through the MCBHD will also be provided that same information and option of medical care and advance directives. An advance directive can be initiated before or after the consumer loses the ability to make decisions for themselves. An advance directive can be revoked at any time. [The written information flyer and documentation must be updated as soon as possible, but no later than 90 days after a change in state law (Attachment 2)]. The documentation of the receipt of that information will be noted in the consumer's chart (see ATTACHMENT 8). Natividad Medical Center (NMC) inpatient admissions provides consumers with an additional informational pamphlet (ATTACHMENT 4) as well as an Advance Directive Admission Statement (ATTACHMENT 3).

   Staff need to keep in mind only a judge can remove a consumer's right to self-choice. Having a Power of Attorney does not remove the consumer's right to self-choice. The advance directive would not apply to psychotropic medication as a "Riese Hearing" would apply (patient's refusal to voluntarily take psychotropic medication – *Riese v St. Mary's Hospital & Medical Center (1987) 209 CA 3d 1303, 243 CR 241, Welfare and Institutions Code 5332-5337)*. A Wellness Recovery Plan (WRAP) would not take the place of an advance directive although it could certainly help guide the individual with the Power of Attorney in making decisions on the behalf of the consumer.

2. The MCBHD staff must provide written information regarding implementations of such rights, including a clear and precise statement of limitation if the provider cannot implement an advance directive on the basis of conscience. (It is not meant to preempt any state law that protects providers' rights not to implement an advance directive as a matter of conscience). The material must identify any limitations the hospital or outpatient clinic may have on honoring specific requests based on conscience (e.g. religious belief). The statement of limitation must clarify any differences between hospital-wide or outpatient clinic conscience objections and those that may be raised by individual physicians. The objection must identify the state legal authority authorizing conscience objections, and describe the range of medical

   conditions or procedures affected by the conscience objections (Health Care

Decisions Law).

3. Document in a prominent part of the consumer's medical record whether or not the consumer has executed an advance directive. (That is not just the receipt of a completed Advance Directive Statement but the actual execution of it), as well as its withdrawal.

4. There will not be a condition of the provision of care, or otherwise discrimination against a consumer, based on whether or not he/she has executed an advance directive. A consumer's choice to establish an advance directive OR to NOT establish advance directives will be documented on the Advance Directive form (ATTACHMENT 1 and 8) and will be filed in the legal section of the consumer's file.

5. MCBHD staff will comply with state statutes, regulations, and court decisions regarding advance directives.

6. MCBHD will educate the staff concerning its policies and procedures on advance directives.
    - Power of Attorney for Health Care – that part of an advance directive to appoint an agent to make a health care decision. They must be 18 years of age or older and capable of making the consumer's medical decisions. It can be a relative or friend, or any other person the consumer trusts to speak for them when medical decisions must be made. **IT CAN NOT BE THE CASE MANAGER OR BOARD AND CARE OPERATOR** – see limitations on ATTACHMENT 2. (MCBHD staff may need to assist the consumer in fully understanding who might be a reasonable candidate to act on their behalf).
    - Individual Health Care Instruction – part where the consumer expresses what they want done.

7. Provide the consumer with a Patient's Rights Brochure (ATTACHMENT 2 OR 4, depending on admissions) as part of the hospital/outpatient admission process that identifies the consumer's rights to make decisions regarding their health care, the right to accept or refuse medical or surgical treatment, even if treatment is life-sustaining.

8. Inform consumers that complaints concerning the advance directives may be made to the California Department of Health (916) 552-8700.

9. Admissions to NMC provides the consumer with a variety of Advance Health Directive forms to choose from that can be obtained through the Social Services office at NMC (ATTACHMENTS 5. 6. or 7). The hospital administration will generally accept variations of the directive, provided it meets the guidelines and intent of Patient Self-Determination Act of 1990. Outpatient services will provide the consumer with a copy of YOUR RIGHT TO MAKE DECISIONS ABOUGHT MEDICAL TREATMENT (ATTACHMENT 2), and if the consumer elects to invoke a written advance directive, will be

provided a copy of the ADVANCE HEALTH CARE DIRECTIVE (ATTACHMENT 1), as well as complete ATTACHMENT 8, Advance Directive Admission Statement.

ADVANCE HEALTH CARE DIRECTIVE

INSTRUCTIONS

Part 1 of this form 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 alternate agent 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 a residential care facility where you are receiving care, or you supervising health care provider or an employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.

Unless you state otherwise in this form, your agent will have the right to:

1. Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.

2. Select or discharge health care providers and institutions.

3. Approve or disapprove diagnostic tests, surgical procedures, and programs of medication.

4. Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.

5. Donate organs or tissues, authorize an autopsy, and direct disposition of remains.

However, your agent will not be able to commit you to a mental health facility, or consent to convulsive treatment, psychosurgery, sterilization or abortion for you.

ATTACHMENT 1(ENGLISH)

Part 2 of this form lets you give specific instructions about any aspect of your health care, whether or not you appoint an agent. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, as well as the provision of pain relief. You also can add to the choices you have made or write down any additional wishes. If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out Part 2 of this form.

Give a copy of the signed and completed form 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 agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health care directive or replace this form at any time.

PART 1 – POWER OF ATTORNEY FOR HEALTH CARE

DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

Name of individual you choose as agent: _____

Address: _____

_____

Telephone: _____
(home phone) (work phone) (cell/pager)

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternative agent:

Name of individual you choose as first alternative agent: _____

Address: _____

_____

Telephone: _____
(home phone) (work phone) (cell/pager)

OPTION: If you revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

Name of individual you choose as second alternate agent: _____

Address: _____

_____

Telephone: _____
(home phone) (work phone) (cell/pager)

AGENT'S AUTHORITY: My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep my alive, except as I state here:

_____

_____

_____

_____
(Add additional sheets if needed.)

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. _____
(Initial here)

OR

My agent's authority to make health care decisions for me takes effect immediately.
_____
(Initial here)

AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

STATEMENT OF WITNESSES: I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence (2) that the individual signed or acknowledged this advance directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual[s health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community health care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

FIRST WITNESS

Name: _____ Telephone: _____

Address: _____

_____

Signature of witness: _____ Date: _____

SECOND WITNESS

Name: _____ Telephone: _____

Address: _____

_____

Signature of Witness: _____ Date: _____

ADDITIONAL STATEMENT OF WITNESSES: At least one of the above witnesses must also sign the following declaration:

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance health care directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law.

Signature of Witness: _____

Signature of Witness: _____

YOU MAY USE THIS CERTIFICATE OF ACKNOLEDGMENT BEFORE A NOTARY PUBLIC INSTEAD OF THE STATEMENT OF WITNESSES.

Sate of California)
) SS.
)
County of _____

On (date) _____, before me, (name and title of

officer) _____,

personally appeared (name(s) of signer(s)) _____

personally known to me OR

proved to me on this basis of satisfactory evidence

to be the person(s) whose names(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.

WITNESS my hand and official seal. (Civil Code Section 1189)

Signature of Notary: _____

PART 6 – SPECIAL WINTESS REQUIREMENT

If you are a patient in a skilled nursing facility, the patient advocate or ombudsman must sign the following statement:

STATEMENT OF 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.

Date: _____

Name: _____ _____
(print your name)

Address: _____

_____

AGENT'S POSTDEATH AUTHORITY: My agent is authorized to make anatomical gifts, authorize an autopsy and direct disposition of my remains, except as I state here in Part 3 of this form:

_____

_____

_____

(Add additional sheets if needed.)

PART 2 – INSTRUCTIONS FOR HEALTH CARE

If you fill out this part of the form, you may strike any wording you do not want.

END-OF-LIFE DECISIONS: I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

Choice Not to Prolong Life:

_____ (Initial here) I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits,

OR

Choice to Prolong Life:

_____ (Initial here) I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

RELIEF FROM PAIN: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

_____

_____

_____

_____

(Add additional sheets if needed.)

OTHER WISHES: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here). I direct that:

_____

_____

_____

_____

(Add additional sheets if needed.)

PART 3 – DONATION OF ORGANS AT DEATH (OPTIONAL)

Upon my death:

I give any needed organs, tissues, or parts _____
(Initial here)

OR

I give the following organs, tissues, or parts only: _____
_____ _____
(Initial here)

My gift is for the following purposes:

Transplant _____ (Initial here) Research _____ (Initial here)

Therapy _____ (Initial here) Education _____ (Initial here)

PART 4 – PRIMARY PHYSICAIN (OPTIONAL)

I designate the following physician as my primary physician:

Name of Physician: _____ Telephone: _____

Address: _____

_____

PART 5 – SIGNATURE

This form must be signed by two qualified witnesses, or acknowledged before a notary public.

SIGNATURE: Sign and date the form here:

Date: _____

Name: _____ _____
(print your name)

Address: _____

_____

Attachment Advance Directive--Spanish

DIRECTIVA POR ANTICIPADO DE LA ATENCIÓN DE LA SALUD

INSTRUCCIONES

La Sección 1 de este formulario le permite nombrar a otro individuo como representante para que tome las decisions de atención de la salud por usted en caso que llegue a ser incapaz de tomar sus propias decisions o si usted quiereque alguien mas tome esas decisions por usted ahora aunque todavía siga sievdo capaz. También puede nombrar a un representante suplente que actue por usted sis u primera elección no está dispuesta, no es capaz o no estárazonablemente accessible para tomar decisáiones por usted.

Su representante no puede ser un operador o empleado de un establecimiento de attención comunitaria y un establecimiento de atención residencial donde lo estén attendiendo, ni su proveedor de atención de la salud encargado de la upervision o un empleado de la institución de attención de la salud donde usted estérecibiendo la misma, a menos que su representante esté emparentado con usted o sea companero de trabajo.

A menos que indique lo contrario en este formulario, su representante tendrá el derecho de:

1. Prestar o negar el consentimiento a cualquier atención, tratamiento, servicio o procdeimiento para mantener, diagnosticar o afectar de otro modo una enfermedad fisica o mental.

2. Seleccionar o rechazar proveedores e instituciones de atención de la salud.

3. Aprobar o desaprobar pruebas diagnósticas, procedimientos quirúrgicos y programas de medicamentos.

4. Dirigir el proveimiento, la negación o la retirada de nutrición e hidratación artificial y todas las demás formas de atención de la salud, incluyendo resucitación cardiopulmonary.

5. Donar órganos o tejidos, autorizar una atuopsia y ordenar la disposición final de los restos.

Sin embargo, su representante no podrá internario en un establecimiento psiquiátrico ni dar su consentimiento para que usted sea sometido a tratamiento convulsiovo, psicocirugía, esterilización o aborto.

La Sección 2 de este formulario le permite dar instrucciones especificas acerca de cualquier aspecto de su atención de la salud, ya sea que usted nombre un representante o no. Se proporcionan opciones para que usted exprese sus desios acerca del proveimiento, la negación o la retirada del tratamiento para mantenerio vivo, así como el proveimiento de alivio del dolor. También se proporciona expacio para que usted aumente las opciones que haya hecho o que anote cualexquier deseos adiocionales. Si está conforme con dejar que su representante determine lo que sea major parra usted al tomar decisions relacionadas con el final de la vida, no es necesario que llene la Parte 2 de este formulario.

Entrégueles copia del formulario firmado y degidamente llenado a su medico, a cualexquier otros proveedores de atención de la salud que pueda tener, a cualquier institucióndе atención de la salud en la que lo extén atendiendo y a todos los representantes de atención de la salud que haya nombrado. Deberá hablar con la persona que haya nombrado como representante para asegurar que él o ella entienda sus deseos y esté dispuesta a asumir la responsabilidad.

Usted tiene derecho a revocar esta directive por anticipado de la atneción de la salud o a reempazar exte formulario en cualquier momento.

PARTE 1 – PODER NOTARIAL PARA ATENCIO DE LA SALUD

DESIGNACIÓN DEL REPRESENTANTE: Designo al siguiente individuo como mi representante para que tome las decisions de atencio´n de la salud por mi:

Nombre del individuo que usted elija como representante
_____

Dirección: _____

_____

Teléfono: _____
(en casa) (teléfono en el trabajo) (teléfono cellular)

OPCIONAL: Si revoco la autoridad de mi representante y mi primer reporesnetante suplente o si ninguno de los dos está dispuesto, es capaz o está rezonablemente accessible para tomar una decisio´n de atención de la salud por mi´ Segundo representante suplente a:

Nombre del individuo que usted elija como su irecti representante suplente
_____

Dirección: _____

_____

Teléfono: _____
(en casa) (teléfono en el trabajo) (teléfono cellular)

AUTORIDAD DEL REPRESENTANTE: Mi representante está autorizado para tomar todas las directive de atención de la salud por mí, incluyendo las desisiones para proveer, negar o retirar la mutrisión e hidratacio´n artificial y todas las demás formas de atención de la salud para mantenerme vivo, excepto como lo consigno aquí:
_____
_____
(Si es necesario, agregue hojas adicionales.)
CUA´NDO ENTRA EN VIGENCIA LA AUTORIDAD DEL REPRESENTANTE: La autoridad de mi representante entra en vigencia cuando mi medico de atneción primaria determine que soy incapaz de tomar mis propias decisions de antención de la salud.
_____
(Escribe sus iniciales aquí. Initial here)

OBLIGACIÓN DEL REPRESENTANTED: Mi representante tomará decisions de atención de la salud por mí de acuendo con este poder notarial para atención de la salud, todas las instrucciones que yo propocione en la Parte 2 de este formulario y mis demás deseos en la medida conocida para mi representante. En la medida que mis deseos sean desconocidos, mi representante tomará decisions de atención de la salud por mí de acuerdo con lo que mi

representante determine que es en mi major interés. Para determiner mi major interés, mi representante deberá considerer mis valores personales en la medida conocida por el mismo.

AUTORIDAD DEL REPRESENTANTE DESPUE´S DE LA MUERTE: Mi representante está autorizado para hacer donaciones anatómicas, autorizar una autopia y ordenar la disposición final de mis restos, excepto como yo lo consigno aquí o en la Parte 3 de este formulario:

_____

_____

_____

(Si es necesario, agreque hojas adicionales.)

NOMBRAMIENTO DEL CONSERVADOR: Si es necesario que una corte designe para míun conservador de mi persona, yo nombre al representante designado en este formulario. Si ese reporesentante no está dispuesto, no es capaz o no está razonablemente accessible para actuar como conservador, nomro a los representantes suplentes que he designado, en el orden en que lo he hecho.

PARTE 2 – INSTRUCCIONES PARA LA ATENCION DE LA SALUD

Si usted llena esta parte del formulario, podrá tachar cualquier texto que no quiera.

DECISIONES DEL FINAL DE LA VIDA: Ordeno que mis proveedores de atención de la salud y otros que participen en mi atención de la salud y otros que participen en mi atención provean, nieguen o retiern el tratamiento de acuerdo con la elección que yo haya marcado abajo:

Elección de no prolonger la vida

No quiero que me vida sea prolongada si (1) tengo una enfermedad incurable e irreversi le que resulte en mi muerte dentro de un periodo relativamenta corto, (2) pierdo el conocimiento y, con un grado razonable de certidumbre médica, no lo recuperaré o (3) lost riesgos y cargas probables del tratamiento serían más mayors que lost beneficios previstos, O

Elección de prolonger la vida

Quiero que mi vida sea prolongada tanto como sea possible dentro de lost límites de las normas de atención de la salud generalmente aceptada.

ALIVIO DEL DOLOR: Excepto como lo consigno en el siguiente espacio, ordeno que se me proporcine en todo momento tratamiento para el alivio del dolor o las molestias, aunque acelere mi muerte:

(Si es necesario, agregue hojas adicionales).

OTROS DESEO: (Si usted no está de acuerdo con alguna de las elecciones opcionales que aparecen arriba y desea anotar las suryas propia, o si desa aumentar las instrucciones que ha proporcionado arriba, puede hacerlo aguí).
Ordeno que:

_____

_____

_____

_____
(Si es necesario, agregue hojas adicionales.)

PARTE 3 – DONACION DE ORANOS DESPUES DE LA MUERTE (OPCIONAL)

Después de mi muerte

Dono todos los órganos, tejidos o partes necesarios,
_____
Escriba sus inicales aquí. (Initial here)
O
Dono solamente los siguientes órganos, tejidos o partes.
_____
Escriba sus iniciales aquí. (Initial here)

Mi donación es para los siguintes propósitos (tache cualquiera de los siguientes que usted no desee):

Trasplante _____
Escriba sus iniciales aquí. (Initial here)
Investigación _____
Escriba sus iniciales aquí. (Initial here)
Terapia _____ Educatión _____
Escriba sus iniciales aquí. (Initial here) Escriba sus iniciales aqui.

PARTE 4 – MEDICO DE ATENCION PRIMARIA (OPCIONAL)

Designo al siguiente como mi medico de atendión primaria:

Nombre del Médico: _____ Teléfono: _____

Dirección: _____

_____

OPCIONAL: Si el medico que he designado no está dispuesto, no es capaz o no está razonablemente accessible para actuar como mi medico de atención primaria, designo al siguiente para que desempeñe este papel:

Nombre del Médico: _____ Teléfono: _____

Dirección: _____

_____

PARTE 5 – FIRMA

El formulario debe ser firmado por dos testigos calificados o certificado ante un notario público.

FIRME: Firme y ponga aquí la fecha en el formulario:

Fecha: _____

Nombre: _____ _____
(ponga su firma) (escriba su nombre con letra de molide)

Dirección: _____

_____

DECLARACIÓN DE LOS TESTIGOS: Declaro hajo pena de perjurio conforme a las leyes de California (1) que el individuo que firmó o certifico´ esta directive por anticipado de la atencio´n de la salud es conocido personalmente para mi, o que la identidad del individuo me fue demostrada con evidencia convincente, (2) que el individuao firmó o certificó esta directive por anticipado en mi presencia, (3) que el individuo parece encontrarse en buen estado mental y bajo ninguna presión, fraude o influencia indebida, (4) que no soy la persona designada como representante en esta irective por anticipado y (5) que no soy el proveedor de atanción de la salud del individuo, un empleado del proveedor de atencio´n de la salud del individuao, el operado de un establecimiento de atención comunitaria, un atencio´n residencial para ancianos, ni un empleado de un operador de un establecimiento de atención residencial para personas de edad avanzada.

Nombre: _____ Teléfono: _____

Dirección: _____

_____

Firma del testigo: _____ Fecha: _____

SEGUNDO TESTIGO

Nombre: _____ Teléfono: _____

Dirección: _____

_____

Firma del testigo: _____ Fecha: _____

DECLARACIÓN ADICINAL DE LOS TESTIGOS: Por lo menos uno de los testigos mencionados arriba también emparentado por lazos sanguíneos, matrimonio o adopcio´n con el individuo que formaliza esta directive por anticipado de la atención de la salud, y que a mi leal saber y entender, no tengo derecho a parte alguna del caudal hereditario del individuo después de su muerte bajo un testamento actuamente existente existente o por ministerio de ley.

Firma del testigo: _____

Firma del testigo: _____

PARTE 6 – REQUEIMIENTO DE TESTIGO ESPECIAL

Si usted es paciente en un establecimiento con servicio de enfermería especializada, el abogado o defensor civico del paciente debe firmar la siguiente declaración:

DECLARACIÓN DEL ABOGADO O DEFENSOR CIVICO DEL PACIENTE

Declaro hajo pena de perjurio conforme a las leyes de California que soy abogado o defensor civico del paciente disignado por el Departmento de la Senectud del Estado y que estoy sirviendo como testigo como lo estipula la Sección 4675 del Código Testamentario.

Fecha: _____

Nombre: _____ _____
(ponga su firma) (escriba su nombre con letra de molde)

Dirección: _____

_____

ADVANCE DIRECTIVE STATEMENT

I have received a copy of the “Patient’s Rights” brochure.

Do you have an Advance Directive?

An Advance Directive is a document that a consumer can develop/fill out to help families know what kind of medical care they want in the future when medical decisions must be made and the patient is too sick to make the decision(s) for themselves.

YES, I HAVE AN ADVANCE DIRECTIVE

Did you bring it with you?

Yes. Copy made and placed in current chart.

No. Unable to provide a copy at this time.

NO, I DO NOT HAVE AN ADVANCE DIRECTIVE

I acknowledge receipt of Advance Directive information, “Your Right to Make Decisions About Medical Treatment”.

Who will make decisions about my medical treatment if I become too ill to express my wishes?

Name	Relationship	Phone Number
_____	_____	_____

Signed _____ Date: _____
Patient/Family Representative

Witness _____ Date: _____
MCHD Staff

DECLARACIÓN PARA PACIENTES CON PODER DURADERO

Yo recibí una copia del Folleto (Derechos del Paiente)

¿Tiene usted un Poder Duradero?

Un Poder Duradero es un documento/forma que el paciete puede iniciar/llenar que ayude a su familia hacer decisions edicos cuando el paciente esta muy enfermo y no puede hacerlas por si mismo.

SI, TENGO UN PODER DURADERO.

¿Lo trajo con usted?

Si. La copia esta en el expediente.

No, No puedo proveer una copia al momento.

NO, NO TENGO PODER DURADERO.

Acabo de recibiré la información sobre el Poder Duraders, “Sus Derechos de Hacer Deciones Sobre su Tratamiento Medico”.

Quien hará decisions sobre mi tratamiento medico si estoy muy enfermo para expresar mis deseos.

_____ _____ _____

Nombre Relación Teléfono

Firma: _____ Fecha: _____

Paciente/Represente

Testigo: _____ Date: _____

Personal de MCBHD