

CARNEY & SUGAI, LLP

Janis A. Carney, Esq.

Certified Specialist, Estate Planning, Trust and Probate Law
The State Bar of California Board of Legal Specialization
e-mail - janisc@carneysugai.com

Leslie Yarnes Sugai, Esq.

Certified Specialist, Estate Planning, Trust and Probate Law
The State Bar of California Board of Legal Specialization
e-mail - leslieys@carneysugai.com

The Trinity Building
16450 Los Gatos Blvd., Suite 208
Los Gatos, California 95032
Telephone: (408)356-6886
Fax: (408)356-6024

web site - www.carneysugai.com

Name of Client: _____

File No. _____

MEMORANDUM TO CLIENT REGARDING ADVANCE HEALTH CARE DIRECTIVE

Please read the Advance Health Care Directive Explanation which accompanies this memo.

AGENT

ALTERNATIVE AGENT

Name: _____

Name: _____

Address: _____

Address: _____

Telephone: _____

Please complete this memo as follows:

_____ Enter above the details of person(s) you wish to make Health Care decisions for you in the event of your becoming incapacitated.

- | | | | |
|-----------------------|---|---|--------------------------|
| <u>PART I:</u> | Period during which Agent's authority is effective | - | Select either A or B |
| | Anatomical Gifts - Disposition of Organs, tissues or parts (Qualify if desired) | - | Select either A, B or C |
| | Power to direct disposition of remains | - | Select either A, B or C |
| | Arrangements for Funeral or Memorial Service | - | Initial if desired |
| | Authorization of Autopsy | - | Select either A or B |
| | Nomination of Conservator of Person | - | Enter details |
| | Expiration | - | Enter date if so desired |

-
- | | | | |
|------------------------|---------------------------------|---|-------------------------------|
| <u>PART II:</u> | End-of-Life Decisions | - | Select either A, B, C, D or E |
| | Relief from pain | - | Initial if desired |
| | Hydration and Nutrition | - | Initial if desired |
| | Additional Statement of Desires | - | Complete if desired |

-
- | | | | |
|-------------------------|--------------------------------|---|---|
| <u>PART III:</u> | INSTRUCTIONS FOR PERSONAL CARE | | |
| | Independent Living | - | Initial any of the statements you wish to have included |
-

PART I

Please select one of the following and initial:

PERIOD DURING WHICH AGENT'S AUTHORITY IS EFFECTIVE.

- A. My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions. My agent's authority ceases to be effective when my primary physician determines that I am again able to make my own health care decisions.

Initials

- B. My agent's authority to make health care decisions for me takes effect immediately.

Initials

ANATOMICAL GIFTS

Disposition of Organs, tissues or parts.

- A. Upon my death, my agent may donate any organs, tissues, or parts.

Initials

- B. Upon my death, my agent may donate only the following organs, tissues or parts:

This gift shall be for the following purposes only:

Initials

- C. Upon my death, my agent may not donate any organs, tissues or parts.

Initials

Please select one of the following and initial:

POWER TO DIRECT DISPOSITION OF REMAINS

- A. My agent shall have the power and authority to direct the disposition of my remains according to his/her discretion.

Initials

- B. My agent shall have the power and authority to direct the disposition of my remains according to my desires as follows:

Initials

- C. My agent shall not have the power or authority to direct the disposition of my remains.

Initials

ARRANGEMENTS FOR FUNERAL OR MEMORIAL SERVICE (OPTIONAL)

My agent shall have the power and authority to arrange for my funeral or other memorial service.

Initials

Please select one of the following and initial:

AUTHORIZATION OF AUTOPSY

- A. My agent shall have the power and authority to authorize an autopsy.

Initials

- B. My agent shall not have the power or authority to authorize an autopsy.

Initials

B. Treat Unless in Irreversible Coma

I want to receive medical treatment that prolongs and sustains my life unless I am in an irreversible coma. By an "irreversible coma" I mean a coma from which the treating physician or physicians have reasonably concluded I will never regain consciousness. If I am in such an irreversible coma, I do not want to receive medical treatment that prolongs and sustains my life.

Initials

C. No Life-Sustaining Procedures if in Terminal Condition

If I am in a terminal condition, I do not want any life-sustaining procedures to be used to prolong my life. For purposes of this document, (1) "terminal condition" shall mean an incurable condition caused by injury, disease, or illness, which, regardless of the application of life-sustaining procedures, would, within reasonable medical judgment, produce death and in which the application of life-sustaining procedures serves only to postpone the moment of my death; and (2) "life-sustaining procedures" shall mean any medical procedure or intervention that utilizes mechanical or other artificial means to sustain, restore, or supplant a vital function which will serve only to artificially prolong the moment of my death. The term "life-sustaining procedures" shall not include the administration of medication or the performance of any medical procedure deemed necessary to alleviate pain.

Initials

D. Treat to Allow Life as Long as Possible

I want to live as long as possible; therefore, I want to receive all medical treatment that will prolong and sustain my life within the limits of generally accepted health care standards. I want such treatment provided to me regardless of my chances of recovery, my condition, or the cost of such treatment.

Initials

E. No Statement of Desires

Initials

RELIEF FROM PAIN (OPTIONAL)

I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death. I wish to receive any other forms of palliative care that may ease my suffering.

Initials

HYDRATION AND NUTRITION (OPTIONAL)

I direct that when life-sustaining procedures or treatment are withheld or withdrawn, that hydration and nutrition also be withheld or withdrawn when they are the only means by which my life is being sustained unless necessary for my comfort or alleviation of pain.

Initials

ADDITIONAL STATEMENT OF DESIRES (OPTIONAL)

OTHER WISHES:

Initials

PART III

INSTRUCTIONS FOR PERSONAL CARE

INDEPENDENT LIVING

I wish to live in my home for as long as that is reasonably possible without endangering my physical or mental health and safety, and to receive whatever assistance from household employees or personal care givers as may be necessary to permit me to do so, *provided, however, that in the event my agent determines that appropriate household employees or personal care givers are not available without putting my financial position or physical or mental health or safety at risk, then I wish to live in the least restrictive and most home-like setting deemed appropriate by my agent. I further request that I live as near as possible to my primary residence in order that I may visit with friends and neighbors to the degree my agent believes that I will benefit from such relationships.*

I wish to return home as soon as reasonably possible after any hospitalization or transfer to convalescent care. If my agent determines that I am no longer able to live in my home, I wish that my agent consider alternatives to convalescent care which will permit me as much privacy and autonomy as possible, including such options as placing me in an assisted living facility or board and care facility.

THE LANGUAGE INCLUDED IN THE ABOVE PARAGRAPH IN ITALICS IS OPTIONAL. IF YOU WOULD LIKE TO INCLUDE THIS LANGUAGE, PLEASE INITIAL IN THE SPACE PROVIDED.

Initials

SOCIAL INTERACTION (OPTIONAL)

I wish to be encouraged to maintain my social relationships and to engage in social interaction even if I am no longer able to recognize my family and friends or to fully participate in social activities.

Initials

Please select and initial as desired.

RELIGIOUS OR SPIRITUAL ACTIVITY (OPTIONAL)

My involvement with _____ has been very important to me. I wish to maintain that involvement as long as possible, even if I no longer fully appreciate its significance. To that end, in accordance with my established beliefs and customary activities, my agent shall provide for the presence and involvement of clergy or other persons to attend to my spiritual needs and permit them access to me and shall arrange for my access to activities and publications, including books, tapes, and similar materials, associated with my spiritual involvement.

Initials

My agent shall not in any way impose his/her religious beliefs, or the religious beliefs of others, on me.

Initials

OUTDOOR ACTIVITIES (OPTIONAL)

I wish to spend significant time outdoors. If I can no longer travel, I wish my agent to arrange for trips to local parks and other areas where I may be outdoors in a natural setting.

Initials
