ADVANCE HEALTH CARE DIRECTIVES

INTRODUCTION

INSTRUCTIONS
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This is very important, because if your physician or a licensed psychologist or care provider ever determines that you lack the capacity to make health care decisions - that you are no longer able to make decisions about your own care or treatment - then they must follow the instructions you provided in your advance directive.

Choosing your treatment and care in advance is your right; and an advance directive is a legal document that enables you to exercise this right.

Anyone can help you complete your advance directive EXCEPT your health care providers. You may consult with them about your care, but they cannot serve as your agent, witness or notary.


USE You can specify a particular individual to make healthcare decisions when you lose your own capacity to do this. This is called appointing an agent to make healthcare decisions. This agent will decide what treatment you will receive should you lose your capacity to make healthcare decisions. Appointment of your agent may also be called a power of attorney, and it is one part of your written advance directive. Your advance directive also enables you to specify many health care preferences. For example:

- You may specify what medications you want administered to you and which doctor you want to administer those medications.

- If you need to be hospitalized, you may specify what hospital you want to go to. If you are hospitalized, you may specify who should be notified.

- You may also specify what treatment you do not want, which doctors you do not want, and which hospitals you do not want to go to. You may also specify who you do not want visiting you if you are hospitalized.

- You may specify that experimental treatment may be administered to you or you may specify that you do not want it.

- You may specify that you want electro-convulsive therapy (ECT) or you can specify that you do not want it.

- You may specify the kind of care you want at the end of your life.
**BENEFITS** An advance directive that is correctly implemented and executed offers you the following benefits:

- Promotes your individual autonomy (independence) and empowerment in the recovery from illness;
- Enhances communication between you and your agent, family, friends, healthcare providers, and other professionals;
- Protects you from being subjected to ineffective, unwanted, or possibly harmful treatments or actions; and
- Helps in preventing crises and the resulting use of involuntary treatment or safety interventions that you may not want, such as restraint and seclusion.

**LIMITATIONS** Your provider may provide treatment contrary to that stated in your advance directive when:

- A court issues an order that contradicts your preferences and instructions in the directive, or
- In cases of emergency when you pose an imminent threat to your own safety or the safety of others.

An advance directive does not limit any authority to take you into custody or to admit, retain, or treat you if you are involuntarily hospitalized under state law.

**PROVIDER RESPONSIBILITY**

- Your health care provider(s) must file your advance directive in your medical record.
- Your provider(s) must comply with your advance directive to the fullest extent possible, consistent with reasonable medical practice, the availability of treatments requested, and applicable law.
- Your provider(s) must notify you and/or your agent if they are not willing to comply with your advance directive or the instructions of your agent.

**REVOCATION** If you have the capacity to make healthcare decisions you can revoke or modify your advance directive, including the designation of your agent, at any time.

A decree of annulment, divorce, dissolution of marriage, or legal separation revokes your previous designation of your spouse as your agent, unless otherwise specified in the decree or in the advance directive.
HOW TO UTILIZE AN ADVANCE DIRECTIVE

• You must want to prepare an advance directive that specifies your care and treatment preferences.

• You must sign your advance directive in the presence of two competent adult witnesses, or in the presence of a notary.

• You must give copies of your advance directive to your health care providers and to your agent (if you designated one).

IF YOU NEED HELP:  (1) Writing an advance directive; (2) Getting your advance directive witnessed or notarized; (3) Filing your advance directive with your providers; or (4) Having the instructions in your advance directive followed; please contact the:

• HAWAII DISABILITY RIGHTS CENTER, or
• YOUR OWN ATTORNEY

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INSTRUCTIONS

General Instructions

1. An advance directive is a legal document, and requires your careful thought and preparation. You should talk to your doctor(s) before you prepare your advance directive. You should also talk to the person(s) you intend to designate as your Health Care Agent(s) before you prepare your advance directive.

2. You will need to gather complete names, addresses and telephone numbers for your doctors, service providers and appointed representatives, as well as other information requested on the form, before you can complete your advance directive.

3. If your advance directive is going to be notarized, you will need a valid picture I.D.

4. If the Hawaii Disability Rights Center (HDRC) is assisting you with the preparation of your advance directive, you should anticipate several meetings with your assigned advocate: (1) To discuss the form and information needed; (2) To prepare the first draft of the form; and (3) To sign the completed form.

5. You MUST complete every section of this form by entering one of the following choices in the line at the beginning of each statement:

   • If you want the statement to apply to you, write your initials on this line, and then fill in the following requested information.

   • If you do NOT want this statement to apply to you, write “N/A” on the line, followed by your initials and leave everything else blank. If HDRC prepares your
Advance Directive, they will use the “strikethrough” function of the computer on this section, so it is clear that you do NOT want it to apply to you.

6. NEVER leave any blank space on this form. At the end of any entry, if there is any remaining blank space, draw a line across the blank space, stopping at the middle of the space and writing "Nothing Follows" and then continue the line to the end of the blank space. Write your initials at the end of line on both sides of the blank space. If HDRC prepares your Advance Directive, they will delete all blank spaces as they prepare the form for your signature.

7. Be sure to enter the full, complete name of the Principal at the top of every page.

8. Due to limited resources, If HDRC assists with the preparation of an Advance Directive, they will prepare no more than one complete Advance Directive, and one modified Advance Directive per year per client.

FRONT PAGE AND TABLE OF CONTENTS

1. Enter the full, complete legal name of the Principal.

2. Enter the maiden name and/or any other names used by the Principal.

3. Enter the complete street address (where the Principal lives), City, State and Zip Code.

4. Enter the Birth Date of the Principal.

5. On the Table of Contents section, be sure to check and initial each section completed by / for the Principal. If a section has not been completed, write “N/A” and initial. If HDRC assists with the preparation of the advance directive, they will use the strikethrough function of the computer to clearly indicate that a section has not been prepared.

PART I. MY POWER OF ATTORNEY

I.A. Statement of Intent

Enter your complete legal name on the first blank line.

Indicate your intent to create an advance directive. You can choose one or both options: Medical Health Care – Initial # 1; Mental Health Care – Initial # 2. If the Hawaii Disability Rights Center assists with the preparation of an Advance Directive, they will recommend preparation of both Medical Health and Mental Health directives, because:

- The law specifically allows it: HRS 327G-3(a) – “An advance mental health directive may be a part of, or combined with, a written advance health care directive under chapter 327E.”
• A combined advance directive is efficient, preparing the Principal for any eventuality which may bring the directive into play.
• A combined advance directive reduces the stigma associated with mental illness; and ultimately, the advance directive is not about mental illness, but about loss of capacity which may also result from many other conditions, such as coma, traumatic brain injury, dementia, Alzheimer’s disease, and numerous other conditions which negatively affect decision-making capacity.

Write "N/A" (Not Applicable) and your initials above your entry, on any option you do not choose.

I.B. Designation of my health care agent(s)

A Health Care Agent is a person you choose in advance to make health care decisions for you if you become unable to do so. This person can help make medical decisions for you at the end of life, or any other time you are unable to communicate, such as if you are severely injured in an accident.

1. Initial. Write in the full legal name of your proposed Health Care Agent along with all his/her contact information.

2. Initial. Write in the full legal name of your proposed First Alternate Health Care Agent, along with all his/her contact information. Or, if you do NOT want to name an Alternate, write "N/A" in the blank space at the beginning of the block and write your initials above your entry.

3. Same as number 2.

4. If you are married, you may designate your spouse as your health care agent.

1.C. Authority granted to my agent(s)

1. Initial. Here you are authorizing your health care agent to make health care decisions for you when you are not capable of making these decisions for yourself.

If you want to set any limits on your health care agent’s authority, list them under "EXCEPT AS I STATE HERE:”. At the end of the listing, draw a line across the page, stopping at the middle of page and entering "Nothing follows" and then continuing the line to the end of the page. Enter your initials at the end of line on either side of the page. If there are no limits, enter "None" and your initials under "EXCEPT AS I STATE HERE:”.

2. Initial if you agree with this provision; or, if you don't agree, enter "N/A" and your initials above your entry.

3. Same as number 2.

4. When do you want or Health Care Agent’s authority to become effective? Choose 4.a. OR 4.b. Initial your choice, and enter “N/A” on the one you do not choose.
1.D Preference for and powers of a court-appointed guardian

1. Initial here, if you want your Health Care Agent to be designated as your guardian, if a guardian needs to be appointed. Otherwise, enter "N/A" and your initials above your entry.

2. Initial here, if you want to limit the authority of an appointed guardian or other decision maker to terminate this directive or to terminate the powers of your Health Care Agent. Otherwise, enter "N/A" and your initials above your entry.

PART II. MY INSTRUCTIONS AND PREFERENCES FOR MY HEALTH TREATMENT

II.A. Designation of my primary physician(s)

Talk to all designated physicians and obtain their consent BEFORE completing this section of the form.

1. Initial. Write in the full legal name of your primary care physician, including the middle initial. This is very important, especially if you are only preparing a “Medical Health Directive.” If you are preparing a “Mental Health Directive” and you do not have a primary care physician, write the name of your psychiatrist in II.A.3. Make sure all contact information is accurate and current.

If you do not have a Primary Care Physician, you may enter, “Attending Physician” and the name of a facility or hospital. Make sure all contact information is accurate and current.

2. Initial. Write in the full legal name, including middle initial, of an alternate Primary Care Physician in case your first choice is not able or available to care for you. Make sure all contact information is accurate and current.

3. Initial. Write in the full legal name, including middle initial, of your psychiatrist. Make sure all contact information is accurate and current.

If you do not want to designate a psychiatrist, enter “N/A” and initial.

4. Initial if you want to include names of other treating or consulting physicians. Use full legal names, including middle initials. Make sure all information is accurate and current.

If you do not want to designate other physicians, enter “N/A” and initial.

5. Many individuals have not had positive experiences with certain medical practitioners. In this part, you have the opportunity to state exactly who you do NOT wish to treat you.
Initial. Enter full legal name(s), including middle initial(s), of those medical practitioners you do NOT want to treat you.

If you do not want to exclude specific medical practitioners, enter “N/A” and initial.

II.B Preferences for hospital and treatment facilities

1. Initial. Enter the name of the hospital(s) or facility(ies) where you have been treated before (the “hospital of record.”) You may list other hospitals or facilities, but if they have not treated you, they do not have to keep your Advance Directive on file.

2. Initial. Some programs and facilities provide care and treatment when hospital care and treatment is not necessary, such as community-based residential care and treatment facilities. In this part, write in the name of such a facility, if you have been provided care and/or treatment there before.

3. Initial. Many individuals, for a variety of reasons, have not had a positive experience at a particular hospital, program or facility in the past. In this part, you have the opportunity to state where you do NOT wish to be provided care and treatment.

II.C. Medications / Allergies

1. Initial, IF you are allowing your Health Care Agent to make decisions about your medications. You can list any limits to this authority in part II.C.4. If you do not want your Health Care Agent to make these decisions, enter “N/A” and initial above.

2. Initial, IF you want to make sure that the medication you are given is regulated at a certain dosage, not to exceed a certain amount. In column 3, you may designate a certain physician or psychiatrist to determine the amount of medication that is right for you. Make sure all information is accurate and current.

3. A physician, other than the one you requested, may be providing your care and treatment. This can happen for many reasons, including emergency, illness, or not having hospital privileges at the hospital where you are being provided care and treatment. Also, several different medications may be used to treat the same condition, and each physician will have favored medication(s).

IF you want to specify certain physician(s) to prescribe your medication(s), initial and complete this section. Make sure all information is accurate and current.

4. Many individuals have experienced harmful side effects to certain medications. IF you want to exclude certain medications, initial this section, and list the drugs you do NOT want to take, listing both brand and generic names. Be sure all information is accurate and current.

5. Medications listed in number 4 may be acceptable to you if dosage is controlled to eliminate side effects. Initial IF you are willing to take this medications as long as they are controlled to prevent or reduce harmful side effects.
6. This part gives specific examples of the different types of side effects you may experience with medication. You may check the type of side effects you prefer not to experience. You may also write in other side effects not indicated. When you complete this part, initial.

7. In this part, you have the opportunity to write in what, if any, medications you are allergic to or what, if any, reactions or side effects you have experienced. When you have completed this section, initial.

8. There may be other issues affecting your medications/allergies that have not been addressed in this section. In this part, you have the opportunity to write in exactly what you feel is important for your Agent and physician to know about your medications/allergies. Initial, and complete.

II.D. Blood Transfusions and blood products

This section gives you the opportunity to state your choices for the use of blood transfusions or blood products during your care.

1. Initial this section, if you do NOT wish to receive blood transfusions or blood products, otherwise enter “N/A” followed by your initials.

2. Initial this section, if you consent to receive blood transfusions or blood products, if needed, otherwise enter “N/A” followed by your initials.

II.E. Experimental studies or drug trials

If you become ill or are hospitalized, your Health Care Agent may be asked to approve the use of an experimental drug for your treatment.

1. Initial if you do NOT want any experimental drug used in your treatment; otherwise enter “N/A” followed by your initials.

2. Initial if you are willing to participate in experimental drug studies or drug trials; otherwise enter “N/A” followed by your initials.

3. Initial if you are giving your Health Care Agent the authority to decide if you should be given experimental drugs; otherwise enter “N/A” followed by your initials.

II.F. Emergency interventions (seclusion, restraint, medications)

If you are hospitalized, “emergency interventions” may become necessary. Please note that #1 deals with interventions related to mental health or behavioral issues. Use the blank space provided in #2 to itemize interventions related to physical conditions.

1. Initial and rank the listed possible interventions from “most-preferred” to “least-preferred.” You may also add and rank other interventions not listed here.
2. Initial and fill in any additional emergency intervention instructions you may wish to include. Examples: You have seizures and how to treat them; or you have a brittle bone condition, and precautions that should be taken when treating you; or you have a fear of being confined in small spaces, and how to respond to that fear when treating you. If you do not want to complete this part, fill in “N.A.” followed by your initials.

II.G. Electroconvulsive therapy (ECT or shock Treatment)

ECT may be considered when all other forms of treatment, such as drug therapy, have failed. ECT is often used to treat severe depression. Some individuals believe they have benefited from ECT, others feel they have not, and are concerned about side effects.

1. Initial here if you do NOT want to be treated with ECT. If you are willing to be treated with ECT, enter “N/A” followed by your initials.

2. There are different types of ECT.
   - 2a. Initial if you agree to ‘Unilateral ECT.” Enter “N/A” followed by your initials if you do not consent to Unilateral ECT.
   - 2b. Initial if you agree to “Bilateral ECT.” Enter “N/A” followed by your initials if you do not consent to Bilateral ECT.
   - You may initial both “2a” and “2b” if you agree to both ECT treatments.

3. You may make choices about the number of ECT treatments, and who determines the number of treatments.
   - 3a. Initial if you want the attending physician to determine the number of ECT treatments. Enter “N/A” followed by your initials if you do not choose this option.
   - 3b. Initial if you want to name a specific psychiatrist to determine the number of ECT treatment. Enter “N/A” followed by your initials if you do not choose this option.
   - 3c. Initial if you want to specify the number of ECT treatments to be administered. Enter “N/A” followed by your initials if you do not choose this option.

4. Initial and fill in any other instructions about the administration of ECT. Enter “N/A” followed by your initials if you do not choose this option. Do not leave any blank space.

PART III. MY INSTRUCTIONS AND PREFERENCES FOR THE END OF MY LIVE

III.A. Prolonging life

We encourage you to speak to your doctor, a trusted advisor and/or family members before completing this section. One of the most challenging issues to consider in
completing an Advance Directive is the issue of prolonging or not prolonging life. This is particularly true when one is dying of an incurable disease such as cancer or being in an irreversible coma.

If you choose to complete this section, you are telling your doctors and Health Care Agent to follow your decision, without feeling guilty.

If you choose not to complete this section, your Health Care Agent will be required to follow his/her best judgment. Your doctors will be required to use heroic measures to keep you alive even when there is no hope of a recovery.

Your documented choice while you are “competent” and have the “capacity” to make choices, may also keep others from interfering with your wishes, or may keep them from being pressured to make decisions when you are near death.

You can choose #1, to prolong life, or #2, to not prolong life. If you choose #2, not to prolong life, then you have three additional choices to consider – (a), (b) or (c). You may choose one, or two, or all three.

III.B Artificial nutrition and hydration

We encourage you to speak to your doctor before completing this section, so that you fully understand your choices regarding artificial nutrition and hydration.

1. Artificial nutrition. Choose 1 or 1a.

2. Artificial hydration. Choose 2 or 2a.

III.C. Relief from pain

Most doctors in hospitals will give pain killers when someone is quite ill. If you choose to complete this section, it will direct your doctors to provide medical treatment to include alleviation of pain or discomfort.

III.D. Donation of organs at death

Many people choose to donate body, organs and tissue at death. This can only happen when the next of kin agree and under special circumstances such as being under life support at time of death.

This section, numbers 1, 2 and 3, give you the opportunity to state your wishes regarding the donation of your organs, tissue and/or other body parts. Number 4 gives you the opportunity to state the purpose of your gift(s).
III.E. Other Wishes

This section allows you to include other wishes related to the end of your life that were not addressed above.

PART IV. ADDITIONAL HEALTH CARE CONSIDERATIONS

IV.A. Notification of my admission to a facility

In this section you have the opportunity to identify individuals you would like to be notified that you have been admitted to a facility. You can also specify if you want them to be permitted to visit you. Please check that all information is accurate and current.

IV.B. Prohibited visitors.

In this section you can identify people you do NOT want to visit you.

IV.C. Other instructions about my health care

This section provides a final opportunity to write any other instructions about your health care that were not addressed in previous sections of the Advance Directive

PART V. DURATION AND REVOCATION

V.A. Duration of my health care directive

1. Initial if you intend to maintain this advance health care directive until you either regain the capacity to make health care decisions for yourself, or you revoke your durable power of attorney for health care, or you revoke all or part of your agent's authority, or your guardian modifies or revokes your durable power of attorney for health care.

2. Initial if you intend to terminate the advance health care directive at the end of 2 years.

V.B. Revocation of my health care directive

1. Initial if you intend to limit your power to revoke, suspend or terminate your advance health care directive to when you have the capacity and competence to do so, otherwise, enter "N/A" and your initials above your entry.

2. Initial if you desire that your health care agent or other decision maker take into account your preferences regarding health care whether you are incompetent or incapacitated or not, otherwise, enter "N/A" and your initials above your entry.
PART VI. SIGNATURE / WITNESSES / NOTARIZATION

VI.A. Signature

You must sign the Advance Directive in the presence of two witnesses or have the document notarized for it to be valid.

VI.B. 1. Verification by two witnesses

If you chose to use witnesses, they must be people known to you and be present when you sign the document. In addition, the witnesses cannot be any person appointed on the Advance Directive; cannot be relatives, beneficiaries, health care providers or employees of a health care provider or facility.

VI.B. 2. Verification by a Notary

In lieu of two witnesses, your Advance Directive may be verified by a state-licensed Notary. There is usually a small charge for this service. Generally, if HDRC prepares your Advance Directive, notary services are provided free of charge.

PART VII. OTHER CONSIDERATIONS

Section VII should not be construed to be a Power of Attorney, but is simply information the preparer of the Advance Directive provides to assist his/her caregivers.

VII.A. Care of my children, pets, finances and property

Enter current and complete names and contact information for those individuals you would like to care for your children, pets, finances and property. Please obtain consent from these individuals before you list their names on this document.

VII.B. My Insurance

Please enter current and complete information about your insurance, especially health, coverage.

VII.C. My Attorney

Enter current and complete name and contact information for your attorney.
VII.D. My Funeral Arrangements

Enter current and complete name and contact information for your funeral arrangements.

PART VIII. ABOUT ADVANCE DIRECTIVES

VIII.A. Preparation and filing of this Advance Health Care Directive

1. Identify the organization and individual(s) who have helped you prepare this Advance Directive.

2. Filing. List everyone who will receive a paper copy of your signed and witnessed (or notarized) Advance Directive. Be sure to include addresses and telephone numbers as well as the first and last name of all medical doctors. At a minimum, the following people and organizations should receive a copy of your Advance Directive:

- Your designated Health Care Agent(s)
- Your Primary Physician(s) and Psychiatrist
- Any hospital where you expect to be treated
- Any programs where you receive services

3. You, the Principal, should keep the ORIGINAL signed and witnessed or notarized Advance Directive.

If the Hawaii Disability Rights Center helps you prepare your Advance Directive, they will mail copies of your Advance Directive to everyone you list, and will also retain a copy in HDRC files.

HDRC will also provide you with a card to carry in your wallet indicating that you have an Advance Directive.
ADVANCE HEALTH CARE DIRECTIVES

The predecessor to this document was created by the BAZELON CENTER FOR MENTAL HEALTH LAW. This version of the Advance Health Care Directive was developed as a collaborative undertaking of mental health consumers and providers with the HAWAII DISABILITY RIGHTS CENTER.

This form complies with all the requirements of the P.L. 101-508 - Patient Self-Determination Act of 1990, HRS 327 E 1-16 - Uniform Health-Care Decisions Act, HRS 327 G - Advance Mental Health Care Directives.

For more information about advance directives please contact: the HAWAII DISABILITY RIGHTS CENTER or the Hawaii State Department of Health, Adult Mental Health Division, OFFICE OF CONSUMER AFFAIRS. Telephone: (808) 586-4688 Fax: (808) 586-4745 Website: www.amhd.gov

For assistance with (1) Writing an advance directive; (2) Getting your advance directive witnessed or notarized; (3) Filing your advance directive with your providers; or (4) Having the instructions in your advance directive followed; please contact the: HAWAII DISABILITY RIGHTS CENTER or YOUR OWN ATTORNEY.
The Hawaii Disability Rights Center

is the designated Protection and Advocacy (P&A) System
for Hawaii’s estimated 210,000 residents with disabilities.

P&A systems are authorized by Congress in each state and territory of the United States to defend and enforce the human, civil and legal rights of people with disabilities and to protect them from discrimination.

HUMAN RIGHTS are those natural rights that are accorded to all human beings, stated in the U.S. Constitution as the right to Life, Liberty and the Pursuit of Happiness.

CIVIL RIGHTS are an expansion of basic human rights and are stated in the U.S. Constitution, the U.S. Bill of Rights and the Hawaii State Constitution. They include the rights to: Freedom of Religion, Speech, Press, Assembly, Equal Protection under the Law, Privacy, Confidentiality.

LEGAL RIGHTS are an expansion of our human and civil rights as established by specific laws, such as those laws which authorize Protection & Advocacy for people with disabilities.

IT IS THE POLICY OF HDRC to advocate for as many people with disabilities in the State of Hawaii, on as wide a range of disability rights issues, as our resources allow; and to resolve rights violations with the lowest feasible level of intervention; but, if necessary, to also provide full legal representation to protect the rights of people with disabilities, consistent with authorizing statutes and Center priorities.

HDRC SERVICES

■ No Income Requirements ■ No Forms to Complete ■ Always Free

TO REQUEST ASSISTANCE
Visit Our Office ■ Call Us ■ Visit Our Website

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