



## Advance Health Care Directive Questionnaire

The following portions of your Advance Health Care Directive will require information from you. Please consider these terms and what persons, decisions, and information might be included. You are not expected to understand all of the options available to you, however it is a good starting point for you to consider for yourself how you would complete these terms before you are provided with examples of terms and information that are commonly used

I look forward to answering your questions and working with you to finalize the content of your Advance Health Care Directive. --DJB

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)

\_\_\_\_\_  
(home phone)

\_\_\_\_\_  
(work phone)

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 alternate agent:

\_\_\_\_\_  
(name of individual you choose as first alternate agent)

\_\_\_\_\_  
(address)

\_\_\_\_\_  
(city)

\_\_\_\_\_  
(state)

\_\_\_\_\_  
(ZIP Code)

\_\_\_\_\_  
(home phone)

\_\_\_\_\_  
(work phone)

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If I 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:

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(name of individual you choose as second alternate agent)

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(address) (city) (state) (ZIP Code)

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(home phone) (work phone)

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 me alive, except as I state here:

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(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 unless I mark the following box.

If I mark this box  , my agent's authority to make health care decisions for me takes effect immediately.

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 or in Part 3 of this form:

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(Add additional sheets if needed)

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:

(a) Choice Not To Prolong Life

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

(b) Choice To Prolong Life

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:

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(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:

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(Add additional sheets if needed)

DONATION OF ORGANS: Upon my death (mark applicable box):

(a) I give any needed organs, tissues, or parts, OR

(b) I give the following organs, tissues, or parts only.

(c) My gift is for the following purposes (strike any of the following you do not want):

(1) Transplant

(2) Therapy

(3) Research

(4) Education

(d) I do not want to give any needed organs, tissues, or parts.

DISPOSITION OF REMAINS: Upon my death (mark applicable box):

(a) I direct that my remains shall be buried, OR

(b) I direct that my remains shall be cremated.

ACCESS TO MEDICAL RECORDS: The following person(s) are authorized to request, review and receive any information, verbal or written, regarding my personal affairs or my physical or mental health, including medical and hospital records, and to execute any releases or other documents that may be required in order to obtain the information. Each of these designated person(s) shall be considered a personal representative of mine under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

- 1.
- 2.
- 3.
- 4.
- 5.

OTHER WISHES: (If you have wishes concerning last rites, funeral instructions, and/or burial services 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:

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(Add additional sheets if needed)

I designate the following physician as my primary physician:

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(name of physician)

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(address) (city) (state) (ZIP Code)

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(phone)

OPTIONAL: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

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(name of physician)

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(address)

(city)

(state)

(ZIP Code)

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(phone)