



Covid-19 Addendum to My Advance Health Care Directive

1. This is a page of explanations about how this addendum fits into an Advance Health Care Directive (AHCD) and how to make sure it is honored.
2. This Addendum could stand alone but is designed to be added to an already completed AHCD as it refers only to the medical care you desire if you have a Covid-19 illness.
3. If you do not have an AHCD, you can download one of the fill-in-the-blank AHCDs from the Internet such as https://www.courts.ca.gov/documents/Advanced-HealthCare-Directive-Form_031620.pdf You can name one or more persons as your health care agent(s) to speak for you if you are unconscious or intubated or too confused to speak for yourself and you can indicate what kind of treatment you want for other terminal illnesses such as cancer, heart failure, or stroke, etc.
4. Every one of us has a unique set of beliefs as to what treatments we want done (or not done). So even if the person you chose to be your health care agent does not wish the same treatments for themselves, it is very important that they understand what *you* want AND that s/he is willing to stand up to other family members *and* your medical providers to ensure that you get the level of treatment you want.
5. You must sign and date your AHCD while you are of sound mind. Although it *may* be honored without being witnessed or notarized, it carries more weight if it is. Be sure to sign in front of your witnesses or notary. This form complies with California law. Below is a link that lists each US state and its finalization requirements for AHCDs: <https://www.nolo.com/legal-encyclopedia/finalization-requirements-health-care-directives.html>
6. **Do Not Resuscitate:** If you stop breathing or your heart stops and you do not want to be resuscitated you may want to complete a **POLST** (Physician Orders for Life-Sustaining Treatment) form. Health care providers, especially first responders are not bound by a DNR within an AHCD whereas a POLST is a physician order which must be followed. A blank California POLST form may be accessed at: https://capolst.org/wp-content/uploads/2017/09/POLST_2017_Final.pdf You will need to get a physician to sign it.
7. If you go to an Emergency Room with a suspected Coronavirus diagnosis, *your health care agent will most likely not be allowed to accompany you inside the ER or visit you if you are hospitalized.* So it is essential that you give one copy to your health agent AND take at least *two copies* of your signed AHCDs with you to the ER: one to give to the admitting nurse to be scanned into your medical record and one to have by your bedside. Full AHCDs can be multiple pages long so we advise that if you decide to create this Covid-19 Addendum that you try to get it printed on brightly colored paper and staple it as the top page of your AHCD.
8. This document is not provided as legal advice. San Diego Hemlock Society is not a law firm and cannot provide legal advice. You may wish to have this reviewed by your attorney.



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I. Home Care vs. Hospital Care:

If I develop a Covid-19 infection, I realize that I may become severely ill and confused. If I've lost my mental capacity, I want my health care agent to (choose #1 and "a" or "b" OR #2):

1. ___ Arrange for home-health care to provide pulse oximetry to monitor my oxygen level and, if needed, supplemental oxygen, & intravenous hydration in my home. If my condition worsens and becomes life-threatening (choose "a" or "b"):
 - a. ___ Continue home-health care including enrolling me in hospice care if I am eligible.
 - b. ___ Transport me to the nearest ER even though my health agent, family, and friends will not be able to accompany me.
2. ___ Skip home-health care and immediately transport me to the nearest ER.

II. Hospital Care:

If my ER physician recommends hospitalization, I want (choose #1, 2, 3, or 4):

1. ___ Only comfort care in a regular hospital ward (oxygen and I.V.s, but no ICU).
2. ___ All available treatments except intubation and mechanical ventilation.
3. ___ All available treatments including a trial of intubation and mechanical ventilation to continued only if, in the opinion of my doctors, it is maintaining all of my vital physical and mental capacities. (I understand that if I consent to be intubated, I will have a tube in my windpipe and will not be able to talk. I may also be heavily sedated to keep me from trying to pull out the breathing tube.)
4. ___ Request all available treatments including intubation and mechanical ventilation for as long as my heart is beating. This may require a tracheostomy.

III. If it is determined that I am terminally ill (*wherever I am receiving care*) and I appear to be in pain or panicked from shortness of breath, (choose "a" or "b" below):

a. ___ **I do not want** b. ___ **I do want** to receive strong opioids and sedative medication so that my panic can be fully relieved even if the physicians warn that these medications may hasten my death.

IV. Do Not Resuscitate: If I develop a serious Covid-19 illness and my heart stops beating:

___ **I do not** ___ **I do** want to have Cardiopulmonary Resuscitation (CPR).

V. Other requests: _____

My health care agent is: _____ Phone #: _____

My alternate health care agent is: _____ Phone # _____

Signature _____ Date _____

Print name _____

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STATEMENT OF WITNESSES: I declare under penalty of perjury under the laws of California that:
The individual . . .

- (1) who signed or acknowledged this advance health care directive is personally known to me, or that his/her identity was proven to me by convincing evidence,
- (2) signed or acknowledged this advance directive in my presence,
- (3) appears to be of sound mind and under no duress, fraud, or undue influence,

I am not . . .

- (4) a person appointed as health care agent by this advance directive,
- (5) the individual's health care provider, the operator of a community care facility, the operator of a residential care facility for the elderly; nor am I an employee of such provider or facilities,
- (6) related to the individual executing this 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 **(THE FIRST WITNESS must include (6); the SECOND WITNESS need not).***

FIRST WITNESS

SECOND WITNESS

Print Name

ADDRESS (Include city and state)

Print Name

ADDRESS (Include city and state)

SIGNATURE & DATE *I am not related or entitled.

SIGNATURE & DATE *I ___am ___am not related/entitled.

Signature

Date

Signature

--

Date

Note: If the individual executing this directive is living in a skilled nursing facility, the facility's patient advocate or ombudsman must be one of the witnesses & sign an additional statement to that effect even if a notary is used.

OR

Certificate of Acknowledgement of Notary Public

(A notary may use page to place his/her acknowledgment, or add an additional page)