



使用此表格，以便在您無法自己做決定時，對您的醫療護理提出意見。表格分為三個步驟：
Use this form to have a say in your medical care if you become unable to make your own decisions. The form has three steps:

步驟1：指定您的醫療護理代理人

Step 1: Name your health care agent

步驟2：填寫您的醫療護理指示

Step 2: Write down your health care instructions

步驟3：簽署表格以使其具有法律效力

Step 3: Sign the form to make it legal

這是以下人士的預先醫療護理指示：

This is the Advance Health Care Directive of:

姓名

Name

出生日期

Date of Birth

當此表格填寫完成後：

When this form is complete:

- 將複印件提供給您的醫療團隊、醫療護理代理人和家人。
Share copies with your medical team, health care agent, and family
- 將原件保存在安全的地方。
Keep the original in a safe place
- 與您的醫療護理代理人 and 親人討論您在醫療護理方面最在意的是什麼。
Talk with your health care agent and loved ones about what matters most to you in your health care

請記住：

Remember:

- 您有權撤銷或更改此預先醫療護理指示。
You have the right to revoke or change this Advance Health Care Directive
- 您可以通過填寫新的預先醫療護理指示來替換這份預先醫療護理。如果需要，將按照您最新的預先醫療護理指示中的選擇執行。

You can replace this Advance Health Care Directive by completing a new one. If needed, the choices from your most recent Advance Health Care Directive would be followed

步驟1：指定您的醫療護理代理人

Step 1: Name Your Health Care Agent

您的醫療護理代理人將幫助您在無法自己做出決定時做出醫療護理決定。

Your health care agent would help make health care decisions if you were unable to make them for yourself

您的醫療護理代理人應當是：

Your health care agent should be someone who:

- 瞭解您、並且可以幫助您的醫療團隊理解您的醫療護理優先事項的人
Knows you well and can help your medical team understand your health care priorities
- 您信任能夠遵循您的意願並為您著想的人
You trust to follow your wishes and do what is best for you
- 能在緊急情況下聯繫到的人
Can be reached in an emergency
- 至少18歲以上
Is at least 18 years old

您的醫療護理代理人不能是您的醫療團隊成員。

Your health care agent cannot be a member of your medical team

如果您無法自行做出決定，您的醫療護理代理人可以幫助選擇：

If you become unable to make decisions for yourself, your health care agent can help choose:

- 您的醫院、診所、養老院或居家護理設施、醫療團隊和家庭護理人員
Your hospital, clinic, nursing home or residence, medical team, and in-home caregivers
- 藥物、檢查和治療
Medications, tests, and treatments
- 誰可以查看您的醫療記錄
Who can see your medical records
- 是否開始或停止生命支持治療，如心肺復甦（CPR）、呼吸機（人工呼吸設備）、透析、人工餵養、輸血等
Whether to start or stop life support treatments like CPR (cardiopulmonary resuscitation), a mechanical ventilator (breathing machine), dialysis, artificial feeding, blood transfusions, and more
- 您去世後對您的身體和器官的處置
What is done with your body and organs after you die

我的醫療護理代理人

My health care agent

我希望此人為我的醫療護理代理人，在我無法做決定時幫助我做出醫療護理決策：

I want this person to be my health care agent, to help make my health care decisions if I become unable to make them for myself:

姓名 Name	_____	
關係 Relationship	_____	
	電話 Phone	_____

(可選) 我的備用醫療護理代理人

(Optional) My alternate health care agent

如果第一個人無法履行職責，我希望此人為我的醫療護理代理人，在我無法做決定時幫助我做出醫療護理決策：

If the first person cannot do it, I want this person to be my health care agent, to help make my health care decisions if I become unable to make them for myself:

姓名 Name	_____	
關係 Relationship	_____	
	電話 Phone	_____

(可選) 我的第二備用醫療護理代理人

(Optional) My alternate health care agent

如果前兩人無法履行職責，我希望此人為我的醫療護理代理人，在我無法做決定時幫助我做出醫療護理決策：

If the first and second people cannot do it, I want this person to be my health care agent, to help make my health care decisions if I become unable to make them for myself:

姓名 Name	_____	
關係 Relationship	_____	
	電話 Phone	_____

步驟2：填寫您的醫療護理指示

Step 2: Write Down Your Health Care Instructions

如果您病重或受傷，且無法自行做決定，**步驟2**將幫助確保您在重要的醫療決策中擁有發言權。

If you become critically ill or injured, and you are unable to make your own decisions, Step 2 will help make sure you have a say about important health care decisions.

具體指示：生命支持治療

Specific instructions: life support treatments

生命支持治療是試圖在您身體即將死亡時保持您生存的醫療手段。包括心肺復甦（CPR）、呼吸機（人工呼吸設備）、透析、餵養管、輸血等。

Life support treatments are medical treatments that try to keep your body alive when it would otherwise die. They can include cardiopulmonary resuscitation (CPR), a mechanical ventilator (breathing machine), dialysis, feeding tubes, blood transfusions, and more.

如果我病重或受傷，且瀕臨死亡，我希望：

(在您最認同的一個選擇旁寫下您的名/姓首字母)。

If I were critically ill or injured, and dying, I would want to:

(Put your initials by the one choice you agree with most).

試用所有可能使我存活的生命支持治療。我希望即使幾乎沒有好轉希望，也繼續進行生命支持治療。

Try all life support treatments that might keep me alive. I would want life support treatments to continue even if there was little hope of getting better.

試用可能使我存活的生命支持治療。但是如果這些治療未能幫助我好轉或停止生命支持治療我就不能存活，我希望停止這些治療，並在幫助減輕痛苦的情況下被允許自然死亡。

Have a trial of life support treatments that might keep me alive. But I would want to STOP life support treatments if they did not help me get better or I could not live without them. At that point, I would want to allow a natural death with help to ease pain or suffering.

被允許自然死亡，並接受減輕痛苦的幫助。我不希望接受生命支持治療。

Allow a natural death, with help to ease pain or suffering. I would not want life support treatments

我不確定。

I am not sure.

(可選) 其他任何評論或指示：

(Optional) Any other comments or instructions:

步驟3：簽署表格以使其具有法律效力

Step 3: Sign the Form to Make It Legal

為了使此文件成為法律文件，您必須在兩名證人或一名公證人面前簽署本表格。

(如果您居住在養老院，患者權益代表或監察員也必須簽署)。

To make this a legal document, you must sign the form in front of two witnesses or a Notary Public.

(If you reside in a nursing home, the patient advocate or ombudsman must also sign).

您填寫此部分

You Fill Out This Part

您的簽名 Your signature	_____	日期 Date	_____
正楷姓名 Print your name	_____		
地址 Address	_____		
電話 Phone	_____		

證人填寫此部分

(僅當未由公證人公證時需要)。

Witnesses Fill Out This Part

(This is only needed if a Notary has not notarized the form).

我確認我認識簽署此預先醫療護理指示的人；此人在我面前簽署或確認已簽署表格；並且此人看起來頭腦清醒且未受到脅迫。我也確認我年滿18歲；我不是此表格中指定的醫療護理代理人；我不是此人的醫療提供者；我不是醫療提供者的員工或此人居住的任何醫療設施的員工。

I confirm that I know the person who signed this advance health care directive; this person signed or acknowledged signing the form in my presence; and the person appears to be of sound mind and under no duress. I also confirm that I am 18 years or older; I am not the health care agent designated in this form; I am not the health care provider; and I am not an employee of the health care provider or any health care facility where this person resides.

<u>證人 #1</u> Witness #1	
簽名 Signature	_____ 日期 Date _____
正楷姓名 Print name	_____
地址 Address	_____

證人 #2

Witness #2

簽名

Signature

日期

Date

正楷姓名

Print name

地址

Address

一名證人還必須簽署此聲明：

我也確認我與簽署此表格的人沒有血緣、婚姻或收養關係。此人去世後我不會獲得任何經濟利益（如金錢或財產）。

One witness must also sign this statement:

I also confirm that I am not related to the person who signed this form by blood, marriage, or adoption.

I will not benefit financially (receive money or property) after this person dies.

簽名

Signature

公證人填寫此部分

（僅當未由兩位證人簽字時需要）。

Notary Public Fills Out This Part

(This is only needed if two witnesses have not signed the form).

加利福尼亞州

_____ 郡

State of California

County of

公證人確認證書

公證人或其他填寫此證書的官員僅核實簽署此文件的個人的身份，而不核實該文件的真實性、準確性或有效性。

CERTIFICATE OF ACKNOWLEDGEMENT OF NOTARY PUBLIC

A Notary Public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

於

On

，在我：

before me,

，面前，

此人：

personally
appeared

出現，

並根據充分的證據向我證明其為姓名在本文件中簽署的人，此人亦向我表示其在授權的身份下簽署本文件，且其在本文件上的簽名即表示此人或其代為行事的實體簽署了本文件。

who proved to me on the basis of satisfactory evidence to be the person(s) who name(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

我根據加利福尼亞州法律在偽證處罰下證實上述段落屬實。

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

見證我的簽名和公章。

WITNESS my hand and official seal.

(公證人印章)
(Notary Seal)

簽名

Signature

患者權益代表或監察員填寫此部分

(僅當您是專業護理機構的患者時需要)。

Patient Advocate or Ombudsman Fills Out This Part

(This is only needed if you are a patient in a skilled nursing facility).

我根據加州法律在偽證處罰下聲明我是加州老齡部指定的患者權益代表或監察員，並根據遺囑法第4675條要求擔任見證人。

I declare under PENALTY OF PERJURY under the laws of the State 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.

姓名

Date

日期

Time

簽名

Signature

正楷姓名

Print name

地址

Address