# PATIENT CHECKLIST

- The Hoag Cancer Center is located on the lower campus of the hospital property at One Hoag Drive, Building 41, Newport Beach, CA 92663. (Map attached.) Phone: 949-764-5528.

- Please check in at the Lower Level, 1st Floor Lobby.

- To avoid any delays in your consultation time or possible rescheduling of your appointment, please fill out all of the attached forms prior to your arrival.

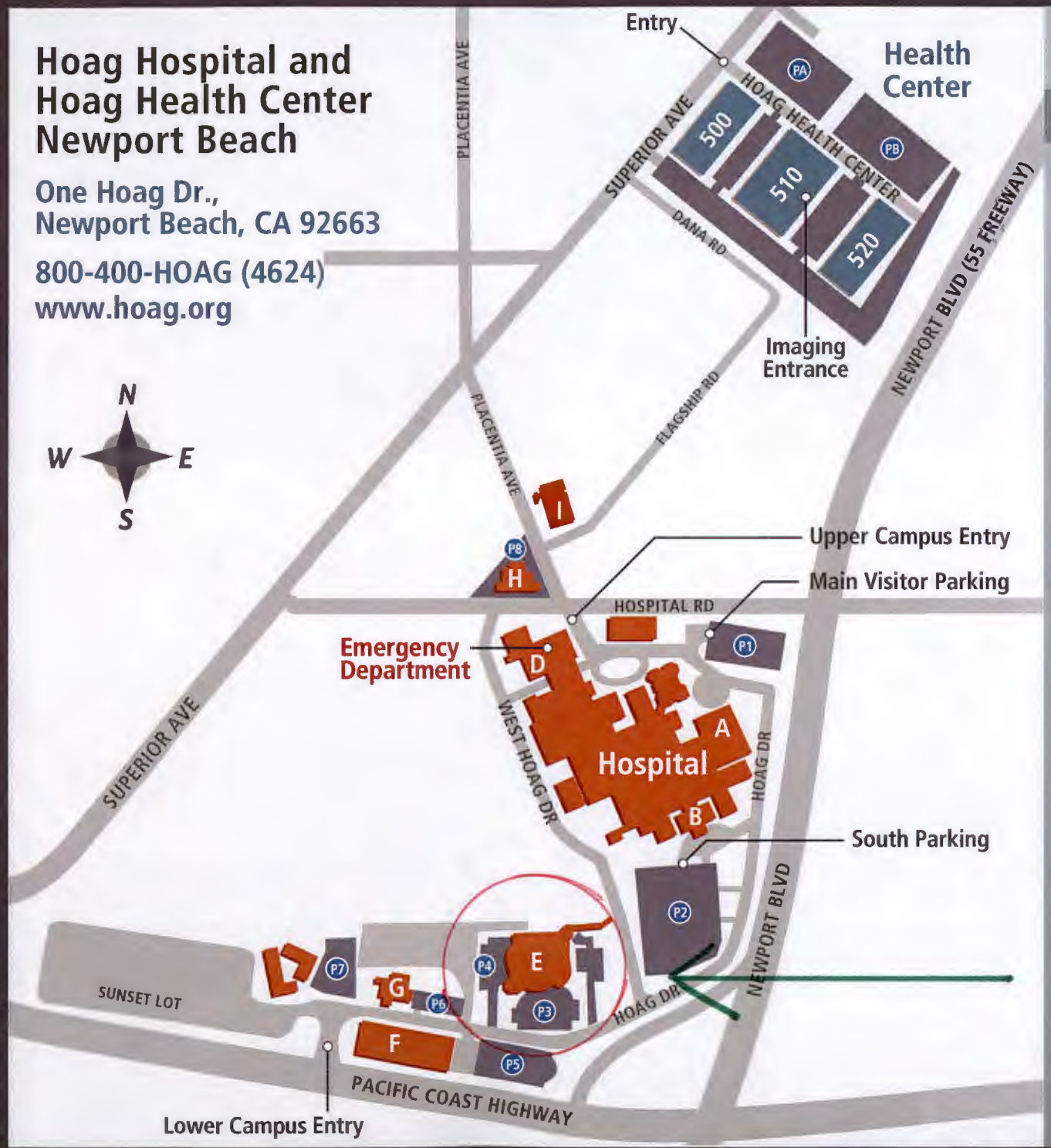
- Please also bring with you a list of current medications. The list should include prescribing physician and dose.

- Should you be unable to complete the attached forms in advance of your appointment, please plan to arrive 45 minutes prior to the appointment so that the forms can be completed and your appointment can start at the scheduled time. *Please be advised that delays in preparing the required paperwork prior to the start of your scheduled appointment time may result in your appointment being rescheduled.*

# Hoag Hospital and Hoag Health Center Newport Beach

One Hoag Dr.,
Newport Beach, CA 92663

800-400-HOAG (4624)
www.hoag.org




hoag

## Find Your Destination

### HOAG CAMPUS

| Destination | Building |
|---|---|
| Advanced Technology Pavilion | G |
| Cancer Center | E |
| Conference Center | F |
| Emergency Department | D |
| Heart & Vascular Institute | B |
| Hospital Main Entrance | A |
| Neurosciences Institute | F |
| South Entrance | B |
| Women's Pavilion | A |
| Center For Healthy Living 307 Placentia Ave. | H |
| Hoag Foundation 330 Placentia Ave. | I |

| | |
|---|---|
| Main Visitor Parking | P1 |
| South Visitor Parking | P2 |
| Cancer Center Parking | P3 P4 |
| Conference Center Parking | P5 |
| Advanced Technology Parking | P6 |
| 307 Placentia Parking | P8 |

### HOAG HEALTH CENTER

| Destination | Building |
|---|---|
| 500 Superior Ave | 500 |
| 510 Superior Ave | 510 |
| 520 Superior Ave | 520 |

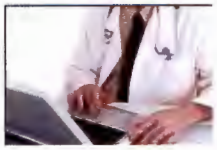
| | |
|---|---|
| Parking Structure A | PA |
| Parking Structure B | PB |

(P) Parking

HHSB Campus Map MASTER 10/2015

hoag
Hoag Family
Cancer Institute

# HOAG RADIATION ONCOLOGY NEW PATIENT PROCESS



## REFERRAL

Your physician will refer you to one of our Radiation Oncologists for a consultation.

## REGISTRATION

The Scheduling Coordinator will obtain all important demographic information from you and will schedule your consultation appointment. Our Scheduling Office can be reached at 949-764-5528.

## CONSULTATION

Your consultation appointment will last 1 to 2 hours. During this time, you will meet with the Radiation Oncologist and a Registered Nurse. Caregivers are welcome to attend.

## SIMULATION

This is your treatment mapping appointment. The CT scan images are used in conjunction with our treatment planning computer to complete the planning process.

Additional nursing education may be provided at this time.

## TREATMENT

Verification

- On your first day, your treatment is verified with imaging and measurements. You may receive treatment on the same day, if indicated.
- Your radiation treatment takes place 5 days per week (Monday-Friday) with weekends off. Your treatment time can take up to 30 minutes.
- You will have weekly visits with your radiation oncologist, a nurse and, in some cases, a dietitian.

## FOLLOW-UP APPOINTMENTS

At the completion of your course of treatment, your Radiation Oncologist will instruct you to meet with our Scheduling Coordinator to schedule your follow-up appointments. These appointments are an important part of your treatment and provide your Radiation Oncologist the opportunity to monitor your progress.

**Please note that the new patient process may take anywhere from 1 to 3 weeks, depending on your circumstances. Should you have any questions, please call us at 949-764-5528.*

HOAG MEMORIAL HOSPITAL PRESBYTERIAN

# PATIENT RECORD OF DISCLOSURES

Please provide us with a telephone number at which you may be reached during the day in case we need to contact you regarding your daily appointment(s).

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone: _____
- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Cell Telephone: _____
- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Work Telephone: _____
- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Other: _____
- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication
- ☐ OK to mail to my work/office address:

  _____

  _____

- ☐ OK to Email to this address:

  _____

- ☐ OK to Fax information to this number:

  _____

☐ Ok to Email regarding Cancer Center services or classes. Email address:

_____

***Optional:*** I authorize Hoag Hospital to discuss my treatment and care with:

Name: _____ Relationship: _____ Telephone: _____

Name: _____ Relationship: _____ Telephone: _____

Name: _____ Relationship: _____ Telephone: _____

Patient Signature: _____ Date: _____ Time: _____

Print Name: _____ Date of Birth: _____

*** Please notify us if any of your information changes***

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses on disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures.

HOAG MEMORIAL HOSPITAL PRESBYTERIAN

# INITIAL NURSING ASSESSMENT
## Radiation Oncology

Patient Name: _____ Date of Birth: _____ Today's Date: _____
Occupation: _____ Family Present: _____
Diagnosis: _____ Physician referred by: _____
Physicians: _____

Height: _____ Weight: _____

**HISTORY OF PRESENT ILLNESS:**

Reason for this visit: _____
_____

Prior radiation therapy? ☐ No ☐ Yes, Site treated: _____ Facility: _____
Prior records available? ☐ No ☐ Yes, _____
Prior chemotherapy? ☐ No ☐ Yes, Last treatment: _____ Facility: _____
Prior hormonal therapy? ☐ No ☐ Yes, Last treatment: _____ Facility: _____
Have you received the flu vaccine this year? ☐ No ☐ Yes, when? _____

**ALLERGIES (list medication/reaction):** _____
_____

**PAST MEDICAL HISTORY (please list all):**

Major Medical Problems: _____
_____

Prior Surgeries: _____
_____

Family History of Cancer (relation, type): _____
_____

**SOCIAL HISTORY/HABITS:**

Marital Status: ☐ Single ☐ Married ☐ Widow ☐ Separated ☐ Divorced
Lives with: _____
Fluent English? ☐ No ☐ Yes Primary Language: _____
Interpreter Needed? ☐ No ☐ Yes, Interpreter: _____
Do you suffer from insomnia? ☐ No ☐ Yes
Do you use (require) a sleep aid? ☐ No ☐ Yes
Do you consume alcohol? ☐ No ☐ Yes, Drinks per day? _____
Quit Date: _____ Describe treatment (if any): _____
Have you used tobacco? ☐ No ☐ Yes, # of years? _____ Packs per day? _____
Quit Date: _____ Assistance needed to abstain? ☐ No ☐ Yes
Do you use recreational drugs? ☐ No ☐ Yes, Type: _____

## REVIEW OF SYTEMS:

### CONSTITUTIONAL

| | | | | | |
|---|---|---|---|---|---|
| Fatigue | ☐ No | ☐ Yes | Night Sweats | ☐ No | ☐ Yes |
| Fatigue Level (1-5): _____ | | | Weight loss | ☐ No | ☐ Yes, ____ lbs _____months |
| KPS (RN to complete): _____ | | | Sudden weight gain | ☐ No | ☐ Yes, ____ lbs |
| Fevers | ☐ No | ☐ Yes | | | |

### EYES

| | | | | | |
|---|---|---|---|---|---|
| Blurred vision | ☐ No | ☐ Yes | Blindness | ☐ No | ☐ Yes: Right / Left / Both |
| Cataracts | ☐ No | ☐ Yes | Require glasses | ☐ No | ☐ Yes |
| Glaucoma | ☐ No | ☐ Yes | Require contacts | ☐ No | ☐ Yes |

### EARS, NOSE, MOUTH, THROAT

| | | | | | |
|---|---|---|---|---|---|
| Hearing loss | ☐ No | ☐ Yes | Hearing aid(s) | ☐ No | ☐ Yes |
| If yes: Right / Left / Both | | | Dentures/Partials | ☐ No | ☐ Yes: Upper / Lower / Both |
| Hoarseness | ☐ No | ☐ Yes | Dental problems | ☐ No | ☐ Yes |
| Difficulty swallowing | ☐ No | ☐ Yes | Requires consult | ☐ No | ☐ Yes |

### CARDIOVASCULAR/RESPIRATORY

| | | | | | |
|---|---|---|---|---|---|
| Heart attack | ☐ No | ☐ Yes | Shortness of breath | ☐ No | ☐ Yes: Oxygen @ _____ L/min |
| Stroke | ☐ No | ☐ Yes | Able to lay flat | ☐ No | ☐ Yes |
| Angina | ☐ No | ☐ Yes | Difficulty laying flat | ☐ No | ☐ Yes |
| Pacemaker/AICD | ☐ No | ☐ Yes | Sleep apnea | ☐ No | ☐ Yes |
| High blood pressure | ☐ No | ☐ Yes | Coughing up blood | ☐ No | ☐ Yes |
| Cough | ☐ No | ☐ Yes | Emphysema/COPD | ☐ No | ☐ Yes |
| Asthma | ☐ No | ☐ Yes | Asbestos exposure | ☐ No | ☐ Yes |

### GASTROINTESTINAL

| | | | | | |
|---|---|---|---|---|---|
| Nausea | ☐ No | ☐ Yes | Jaundice | ☐ No | ☐ Yes |
| Vomiting | ☐ No | ☐ Yes | Liver disease | ☐ No | ☐ Yes |
| Constipation | ☐ No | ☐ Yes | Hiatal hernia | ☐ No | ☐ Yes |
| Diarrhea | ☐ No | ☐ Yes | Heartburn | ☐ No | ☐ Yes |
| Blood in stool | ☐ No | ☐ Yes | Ulcer | ☐ No | ☐ Yes |
| Hemorrhoids | ☐ No | ☐ Yes | Feeding tube | ☐ No | ☐ Yes |
| | | | # ____ cans of _____ per day | | |

### GENITOURINARY

| | | | | | |
|---|---|---|---|---|---|
| Burning with urination | ☐ No | ☐ Yes | **Female:** | | |
| Blood in urine | ☐ No | ☐ Yes | Vaginal itch/discharge | ☐ No | ☐ Yes |
| Frequent urination | ☐ No | ☐ Yes | If yes, describe: _____ | | |
| Urgency to urinate | ☐ No | ☐ Yes | Hormone replacement therapy | ☐ No | ☐ Yes, # of Years: ____ |
| Urinary incontinence | ☐ No | ☐ Yes | Last menstruation: _____ | | |
| **Male:** Prostate problems | ☐ No | ☐ Yes | Menopause | ☐ No | ☐ Yes, at Age: _____ |
| | | | Number of pregnancies: _____ | | |
| | | | Number of live births: _____ | | |
| | | | Age at first pregnancy: _____ | | |

## REVIEW OF SYSTEMS (continued)

### INTEGUMENTARY

| | | | |
|---|---|---|---|
| Rashes | ☐ No | ☐ Yes, Location: | |
| Healing incisions | ☐ No | ☐ Yes, Location: | |
| Sores/Wounds | ☐ No | ☐ Yes, Location: | |
| New lumps/bumps | ☐ No | ☐ Yes, Location: | |
| Swelling | ☐ No | ☐ Yes, Location: | |
| IV Access Device | ☐ No | ☐ Yes, Type: | |
| History of skin cancer | ☐ No | ☐ Yes, Location: | and Type: |

### NEUROLOGICAL/PSYCHIATRIC

| | | | | | |
|---|---|---|---|---|---|
| Headaches | ☐ No | ☐ Yes | Psychiatric Disorders | ☐ No | ☐ Yes |
| Depression | ☐ No | ☐ Yes | Developmental Disorders | ☐ No | ☐ Yes |
| Dizziness | ☐ No | ☐ Yes | Seizures | ☐ No | ☐ Yes, Frequency: |
| Fainting | ☐ No | ☐ Yes | Numbness or Tingling | ☐ No | ☐ Yes, Location: |

Confusion: ☐ No ☐ Yes Memory: ☐ Good ☐ Fair ☐ Poor

Learning Preference: ☐ Written ☐ Verbal ☐ Video Barriers: ☐ No ☐ Yes, Specify:

### ALLERGIC/IMMUNOLOGIC

Autoimmune disorder ☐ No ☐ Yes, Type: Seasonal allergies ☐ No ☐ Yes

Food or other allergies ☐ No ☐ Yes, Explain:

### MUSCULOSKELETAL

| | | | | | |
|---|---|---|---|---|---|
| Fall risk | ☐ No | ☐ Yes | Arthritis | ☐ No | ☐ Yes, Location: |
| Balance difficulty | ☐ No | ☐ Yes | Assistive device | ☐ No | ☐ Yes, Type: |
| Weakness | ☐ No | ☐ Yes | Generalized weakness | ☐ No | ☐ Yes, Site: |
| Paralysis | ☐ No | ☐ Yes, Location: | | | |

Movement of extremities:

☐ Normal ☐ Decreased in Right/Left upper extremities ☐ Decreased in Right/Left lower extremities

Activities of Daily Living: ☐ No limits ☐ Needs dressing assistance ☐ Needs meal assistance

### ENDOCRINE

| | | | |
|---|---|---|---|
| Diabetes | ☐ No | ☐ Yes | |
| Insulin dependent | ☐ No | ☐ Yes | |
| Thyroid disorder | ☐ No | ☐ Yes: | ☐ low ☐ overactive |

### HEMATOLOGIC

| | | |
|---|---|---|
| Anemia | ☐ No | ☐ Yes |
| Bleed easily | ☐ No | ☐ Yes |
| Using blood thinning medication | ☐ No | ☐ Yes |
| Infection requiring isolation | ☐ No | ☐ Yes |

Type (if known):

### PAIN

Area of pain:

Cause of pain:

Type (describe pain):

Does the pain move (where):

Time of onset: Intensity Level (**0=no pain 10=worst pain**):

What relieves the pain?

Patient has problems with: ☐ Child care ☐ Spiritual issues ☐ Financial issues ☐ Transportation

Explain:

**Completed By:**

| | | | | | | |
|---|---|---|---|---|---|---|
| Advance Directive: | ☐ Yes | ☐ No | ☐ Pamphlet given | ☐ Copy received | ☐ In Hoag System | ☐ In electronic chart |
| Video: | ☐ Yes | ☐ No | ☐ N/A | ☐ Other: | | |
| Discussed: | ☐ Supporting Services | | ☐ Referrals: | | | |

**Reviewed by RN:** **Date:** **Time:**

HOAG MEMORIAL HOSPITAL PRESBYTERIAN

# OUTPATIENT INTAKE MEDICATION LIST
## Radiation Oncology

Allergies and Reactions:

**Patient:** Please list ALL usual medications, including over-the-counter drugs (vitamins, herbals and supplements)

Completed By: _____ Date: _____ Time: _____

Source: _____ RN Verifying List: _____

| Medication | Dose | Route | Frequency | Reason | On Admit | |
|---|---|---|---|---|---|---|
| | | | | | Stop | Continue |
| 1. | | | | | ☐ | ☐ |
| 2. | | | | | ☐ | ☐ |
| 3. | | | | | ☐ | ☐ |
| 4. | | | | | ☐ | ☐ |
| 5. | | | | | ☐ | ☐ |
| 6. | | | | | ☐ | ☐ |
| 7. | | | | | ☐ | ☐ |
| 8. | | | | | ☐ | ☐ |
| 9. | | | | | ☐ | ☐ |
| 10. | | | | | ☐ | ☐ |
| 11. | | | | | ☐ | ☐ |
| 12. | | | | | ☐ | ☐ |
| 13. | | | | | ☐ | ☐ |
| 14. | | | | | ☐ | ☐ |
| 15. | | | | | ☐ | ☐ |
| 16. | | | | | ☐ | ☐ |
| 17. | | | | | ☐ | ☐ |
| 18. | | | | | ☐ | ☐ |
| 19. | | | | | ☐ | ☐ |
| 20. | | | | | ☐ | ☐ |

| Neoadjuvant (N) Concurrent (C) | CHEMO – Drugs | Last Course | Future Course(s) | Medical Oncologist |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

RN Update: _____ Date: _____ MD Reviewed on Admit: _____

RN Update: _____ Date: _____ Date: _____



OUTPATIENT INTAKE MEDICATION LIST
Radiation Oncology

PS 1304 Rev 09/09/10

[4014]

PATIENT LABEL

# CURRENT PHYSICIANS

Referring Doctor name: _____ Hoag Physician: Yes__ No__

Address:_____

Phone number:_____

Primary Care Physician name: _____Hoag Physician: Yes__No__

Address: _____

Phone number:_____

Medical Oncologist name: _____Hoag Physician: Yes__No__

Address: _____

Phone number: _____

Surgeon Name:_____Hoag Physician: Yes__No__

Address: _____

Phone number: _____

Other – Name: _____Hoag Physician: Yes__No__

Specialty or reason seeing this doctor:_____

Address: _____

Phone number: _____

**FORM 3-1**

# ADVANCE HEALTH CARE DIRECTIVE

## *INSTRUCTIONS*

Part 1 of this form lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions, or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you.

Your agent may not be an operator or employee of a community care facility or a residential care facility where you are receiving care, or your supervising health care provider or an employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.

Unless you state otherwise in this form, your agent will have the right to:

1. Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.
2. Select or discharge health care providers and institutions.
3. Approve or disapprove diagnostic tests, surgical procedures, and programs of medication.
4. Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.
5. Donate organs or tissues, authorize an autopsy, and direct disposition of remains.

However, your agent will not be able to commit you to a mental health facility, or consent to convulsive treatment, psychosurgery, sterilization or abortion for you.

Part 2 of this form lets you give specific instructions about any aspect of your health care, whether or not you appoint an agent. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, as well as the provision of pain relief. You also can add to the choices you have made or write down any additional wishes. If you are satisfied to allow your agent to determine what is best for you in making end of life decisions, you need not fill out Part 2 of this form.

Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

***You have the right to revoke this advance health care directive or replace this form at any time.***

| | |
|---|---|
| PS 1125 | Patient's Name: |
|  [1214] | MR# |

## PART 1 – POWER OF ATTORNEY FOR HEALTH CARE

### 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: _____

_____

Telephone: _____
*(home phone)* *(work phone)* *(cell/pager)*

OPTIONAL: 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: _____

_____

Telephone: _____
*(home phone)* *(work phone)* *(cell/pager)*

OPTIONAL: 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:

Name of individual you choose as second alternate agent: _____

Address: _____

_____

Telephone: _____
*(home phone)* *(work phone)* *(cell/pager)*

### 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:

_____

_____

_____

*(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.

_____

*(Initial here)*

**OR**

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

_____

*(Initial here)*

### *AGENT'S OBLIGATION:*

My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

### *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:

_____

_____

_____

*(Add additional sheets if needed.)*

### *NOMINATION OF CONSERVATOR:*

If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able or reasonably available to act as conservator, I nominate the alternate agents whom I have named, in the order designated.

## PART 2 – INSTRUCTIONS FOR HEALTH CARE

If you fill out this part of the form, you may strike any wording you do not want.

### 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:

***Choice Not To Prolong Life:***

_____
*(Initial here)*

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**

***Choice To Prolong Life:***

_____
*(Initial here)*

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:

_____

_____

*(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:

_____

_____

_____

_____

*(Add additional sheets if needed.)*

## PART 3 – DONATION OF ORGANS AT DEATH (OPTIONAL)

I. Upon my death:

I give any needed organs, tissues, or parts. _____
*(Initial here)*

**OR**

I do *not* authorize the donation of any organs, tissues or parts. _____
*(Initial here)*

**OR**

I give the following organs, tissues, or parts only: _____

_____

_____
*(Initial here)*

II. If you wish to donate organs, tissues, or parts, you must complete II. and III.

My gift is for the following purposes:

Transplant _____ *(Initial here)*  Research _____ *(Initial here)*

Therapy _____ *(Initial here)*  Education _____ *(Initial here)*

III. I understand that tissue banks work with both nonprofit and for-profit tissue processors and distributors. It is possible that donated skin may be used for cosmetic or reconstructive surgery purposes. It is possible that donated tissue may be used for transplants outside of the United States.

1. My donated skin may be used for cosmetic surgery purposes.

Yes _____ *(Initial here)*  No _____ *(Initial here)*

2. My donated tissue may be used for applications outside of the United States.

Yes _____ *(Initial here)*  No _____ *(Initial here)*

3. My donated tissue may be used by for-profit tissue processors and distributors.

Yes _____ *(Initial here)*  No _____ *(Initial here)*

(Health and Safety Code Section 7158.3)

## PART 4 – PRIMARY PHYSICIAN (OPTIONAL)

I designate the following physician as my primary physician:

Name of Physician:

Telephone: _____

Address: _____

_____

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:

Name of Physician:

Telephone: _____

Address: _____

_____

## PART 5 – SIGNATURE

The form must be signed by you and by two qualified witnesses, or acknowledged before a notary public.

### SIGNATURE:

Sign and date the form here:

Date: _____ Time: _____ AM / PM

Signature: _____
*(patient)*

Print name: _____
*(patient)*

Address: _____

_____

### STATEMENT OF WITNESSES:

I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence, (2) that the individual signed or acknowledged this advance directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

***FIRST WITNESS***

Name: _____ Telephone: _____

Address: _____

_____

Date: _____ Time: _____ AM / PM

Signature: _____
*(witness)*

Print name: _____
*(witness)*

***SECOND WITNESS***

Name: _____ Telephone: _____

Address: _____

_____

Date: _____ Time: _____ AM / PM

Signature: _____
*(witness)*

Print name: _____
*(witness)*

***ADDITIONAL STATEMENT OF WITNESSES:***

At least one of the above witnesses must also sign the following declaration:

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance health care 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 upon his or her death under a will now existing or by operation of law.

Date: _____ Time: _____ AM / PM

Signature: _____
*(witness)*

Print name: _____
*(witness)*

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 the document.

*YOU MAY USE THIS CERTIFICATE OF ACKNOWLEDGMENT BEFORE A NOTARY PUBLIC INSTEAD OF THE STATEMENT OF WITNESSES.*

State of California )

County of _____ )

)

On *(date)*_____ before me, *(name and title of the officer)* _____

_____ personally appeared *(name(s) of signer(s))* _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose 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.

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

WITNESS my hand and official seal. [Civil Code Section 1189]

Signature: _____ [Seal]
*(notary)*

## PART 6 – SPECIAL WITNESS REQUIREMENT

If you are a patient in a skilled nursing facility, the patient advocate or ombudsman must sign the following statement:

### STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN

I declare under penalty of perjury under the laws 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.

Date: _____ Time: _____ AM / PM

Signature: _____
*(patient advocate or ombudsman)*

Print name: _____
*(patient advocate or ombudsman)*

Address: _____

_____