

Health Care Directives and Durable Power of Attorney for Health Care Decisions

醫療指示和醫療代言人授權書

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The Chinese translation in this document is for the user's convenience only. Its accuracy cannot be guaranteed.
本表格的中文只供參考，如有問題以英文辦本為準。

Take a copy of this with you whenever you go to the hospital. Give a copy to your primary care physician and a copy to your care giver.
入醫院時請帶這表格。將一份交給你的主診醫生，一份交給照顧你的人。

Health Care Directives 醫療指示

I, _____, SSN # 社會保障卡號碼 (If no SSN, then other ID 如果沒有社會保障卡, 其他證件) _____,
a resident at 現在居住在 _____

want everyone who cares for me to know what health care I want when I cannot let others know what I want.

現在向所有照顧我的人士聲明：當我不能再和人交通的時候，我希望接受什麼的醫療服務

I always expect to be given care and treatment for pain or discomfort even when such care might shorten my life, make me feel like not eating, slow down my breathing, or be habit-forming.

在任何情況下，我都期望得到止痛和令我舒服的治療，即使這些治療會加速我去世、令我失去胃口、減慢我的呼吸、和令我對藥物產生依賴。

I want my doctor to try treatments that may get me back to an acceptable quality of life. By acceptable quality of life, I mean living in a way that lets me do the things that are important and necessary to me. Those things are:

我希望醫生提供治療，讓我得回一個可接受的生活質素。「可接受的生活質素」是指我可以做下列我認為對我是必須和重要的事情：

(Examples: the ability to recognize family or friends, make decisions, feed myself, communicate, and take care of myself)

(例如：認識親友的能力、作決定、自我進食、與他人溝通、照顧自己)

I direct that no treatment be given just to delay my dying when I have

我現在指示：在下面的情況下，不要提供只是延長我死亡的治療

- A condition that will cause me to die soon, or 我有一個末期疾病，或者
- A condition so bad (including substantial brain damage or brain disease) that there is no reasonable hope that I will regain a quality of life acceptable to me (as described above) 我有一個疾病，是沒有合理的機會得回一個我上面所列出的「可接受的生活質素」

When I have one of the above conditions, the treatments IDO NOT want include: *(Check when applicable)*

當我有上面的情況時，我拒絕接受的治療包括 (選擇所有適用的)

- Surgery 外科手術
- Doing things to start my heart or breathing, if either stops (CPR) 心肺腹甦法
- Artificial kidney machine (dialysis) 洗腎
- Breathing machine (respirator, ventilator) 機器呼吸
- Food or water given through a tube in the vein, nose, or stomach (tube feedings) 以喉管喂食
- Chemotherapy (cancer treatment) 化療
- Blood transfusions 輸血
- Other treatment 其他的治療 _____

I want to donate my organs or tissues and realize it may be necessary to maintain my body artificially until my organs can be removed.

我願意捐獻我的器官和組織，也明白這可能引致短時間的人工維生，直到器官被移走

yes 是 no 否 undecided 未決定

My other directions include 我其他的指示包括 _____

(Examples: Hospice; death at home, if possible; specific directions regarding organ donation)

(例子：善終服務；希望在家離世；關於捐獻器官的特別指示)

Signature *(Need to sign again on page 2 and have two witnesses sign the form. May need notarization)*

簽名 (需要在表格的第二頁再簽字，並需兩個證人簽字證，可能需要公證)

Date 日期 _____

Talk about this form and your ideas about your health care with the person you have chosen to make decisions for you, your doctor(s), family, friends, and clergy, and give each of them a completed copy. You may cancel or change this form at any time. You should review it every so often. Each time you review it, put your initials and the date here.

你應定時和你的親友、醫生、照顧你的人、宗教人士，和你選擇替你作決定的代表討論這表格的內容和你的意願。將一份這表格交給他們。你可以隨時更改或者取消這表格。你需要定時重溫這表格。每次重溫後，請在下面寫下日期和簽名。

English version of the form is based on a document provided as a service by Midwest Bioethics Center, the Kansas City Metropolitan Bar Association, and the Metropolitan Medical Society of Greater Kansas City.

Durable Power of Attorney for Health Care Decisions 醫療代理人授權書

It is important to choose someone to make health care decisions for you when you cannot. Tell the person (**agent**) you choose what you would want. The person you choose has the same right as you do to make decisions and to make sure your wishes are honored. If you **DO NOT** choose someone to make decisions for you, write **NONE** on the line for the agent's name.

你可以授權其他人士，在你不能作決定的時候，作為你的代理人，替你作出醫療決定。你需要告訴你的代理人（們），你的意願是什麼。如果你不想委任任何人，在代理人一行上寫「無」。

I 我 _____ appoint the person named below to be my agent to make health care decisions for me when and only when I cannot make decisions or communicate what I want done. This is a Durable Power of Attorney for Health Care Decisions and the power of my agent shall not end if I become incapacitated or if there is uncertainty that I am dead. This revokes any prior Durable Power of Attorney for Health Care Decisions. My agent may not appoint anyone else to make decisions for me. I and my estate hold my agent and my caregivers harmless and protect them against any claim based upon following the Durable Power of Attorney for Health Care or my Health Care Directives. Any Costs should be paid from my own resources. I grant to my agent full power to make all decisions for me about my health care, including the power to direct the withholding or withdrawal of life-prolonging treatment. In exercising the power, I expect my agent to be guided by my directions as stated in my Health Care Directives (see page one). My agent is also authorized to (please check where applicable)

現在委任下列人士，在我不能作決定，或者不能和人溝通的時候，替我作出關於醫療方面的決定。這授權書在我失去知覺或者未肯定是否去世的時候繼續有效。這授權書撤消了以前其他的授權書。我的代理人不能再委派其他人士做我的代表。我和我的承繼人，不會因為和這授權書有關的醫療決定，而要求代理人負任何責任。我會為代理人的決定向第三者負責。我會負責所有有關的費用。我的代理人有全權替我作出醫療方面的決定，包括是否不提供或者撤回維生的治療。當替我作決定的時候，我期待我的代理人會跟據我的醫療指示而行（見第一頁）。我的代理人而也有權（請選擇適用的）

- Consent, refuse or withdraw consent to any care, treatment, service or procedure (including artificially supplied nutrition and / or hydration / tube feeding) used to maintain, diagnose or treat a physical or mental condition
同意或者拒絕任何診斷和治療
- Make all necessary arrangements for any hospital, psychiatric treatment facility, hospice, nursing home, or other health care organization; employ or discharge health care personnel (any person who is authorized or permitted by the laws of the state to provide health care services) as my agent shall deem necessary for my physical, mental or emotional well being;
替我作出住院（包括醫院、療養院、精神病院等）和善終服務的安排，聘請醫護人員
- Request, receive, and review any information regarding my physical or mental health, or my personal affairs, including medical and hospital records; execute any releases of other documents that may be required to obtain such information;
要求一切關於我的醫療記錄
- Move me into or out of any State or institution for the purpose of complying with my Health Care Directives or the decisions of my agent;
將我搬遷到其他地方（包括搬到其他的州）
- Take legal action, if needed, to do what I have directed
啟動法律程序以保障我的意願和權益
- Make decisions about autopsy and organ donation, and the disposition of my body; and
作出關於解剖、捐贈器官、和處理遺體的決定
- Become my guardian if one is needed.
在有需要時作我的監護人

Agent's Name 代理人姓名 _____ Phone 電話 _____

Address 地址 _____

Alternate Agent's Name 交替代理人姓名 _____ Phone 電話 _____

Address 地址 _____

SIGN HERE for the Health Care Directives and the Durable Power of Attorney Forms. Many states require notarization. Please ask two persons to witness your signature that are not related to you nor financially connected to you or your estate.

在這裏簽名。你居住的州可能需要公證。需要兩個沒有親戚關係、和你和你的承繼人沒有經濟關係的人士做證人。

Signature 簽名 _____ Date 日期 _____

Witness 證人 _____ Date 日期 _____ Witness 證人 _____ Date 日期 _____

Address 地址 _____ Address 地址 _____

NOTARIZATION 公證

On this ___ day of _____, in the year of _____, personally appeared before me the person signing, known by me to be the person who completed this document and acknowledged it as his/ her free act and deed. IN WITNESS WHEREOF, I have set my hand and affixed my official seal in the County of _____, State of _____, on the date written above

Notary Public _____ Commission Expires _____