ក្រុមបណ្តាល្ គា ប់ថែទាំេុខភាពជាមុន រដ្ឋកាលដីហ្វ័រនដីញ៉ា  California Advance Health Care Directive

This form lets you have a say about how you want to be treated if you get very sick.

This form has 3 parts. It lets you:

- **Part 1:** Choose a health care agent.

  A health care agent is a person who can make medical decisions for you if you are too sick to make them yourself.

- **Part 2:** Make your own health care choices.

  This form lets you choose the kind of health care you want. This way, those who care for you will not have to guess what you want if you are too sick to tell them yourself.

- **Part 3:** Sign the form.

  It must be signed before it can be used.

You can fill out Part 1, Part 2, or both.

Fill out only the parts you want. Always sign the form in Part 3.

2 witnesses need to sign on page 10 or a notary public on page 11.

**YOUR NAME:**

Go to the next page
គ្រប់គ្រងការសករើេសរ ើេការថែទាំេុខភាព ចុះខ្លួននៅក្នុងកកដាេបំសពញ ថ្្នកទដី 1 និង ថ្្នកទដី 2 ។

If you want both then fill out Part 1 and Part 2.

Always sign the form in Part 3 on page 9.

2 witnesses need to sign on page 10 or a notary public on page 11.
PART 1

Choose your health care agent

The person who can make medical decisions for you if you are too sick to make them yourself.

Whom should I choose to be my health care agent?

A family member or friend who:

• is at least 18 years old
• knows you well
• can be there for you when you need them
• you trust to do what is best for you
• can tell your doctors about the decisions you made on this form

Your agent cannot be your doctor or someone who works at your hospital or clinic, unless he/she is a family member.

What will happen if I do not choose a health care agent?

If you are too sick to make your own decisions, your doctors will ask your closest family members to make decisions for you.

If you want your agent to be someone other than family, you must write his or her name on this form.

What kind of decisions can my health care agent make?

Your agent will need to follow the health care choices you make in Part 2.
Life support treatments – medical care to try to help you live longer

• CPR or cardiopulmonary resuscitation

- Cardio = heart
- Pulmonary = lungs
- Resuscitation = to bring back

Cardiopulmonary resuscitation: This may involve:
- Pressing hard on your chest to keep your blood pumping
- Electrical shocks to jump start your heart
- Medicines in your veins

• Breathing machine or ventilator

A machine that pumps air into your lungs and breathes for you. You are not able to talk when you are on the machine.

• Feeding Tube

A tube used to feed you if you cannot swallow. The tube is placed down your throat into your stomach. It can also be placed by surgery.

• Blood transfusions

To put blood in your veins.

• Surgery

• Medicines

End of life care – if you might die soon your health care agent can:
- Call in a spiritual leader
- Decide if you die at home or in the hospital

California Advance Health Care Directive

Show your health care agent this form. Tell your agent what kind of medical care you want.
Your Health Care Agent

I want this person to make my medical decisions.

(first name)  (last name)
(street address)  (city)  (state)  (zip code)
(home phone number)  (work phone number)

If the first person cannot do it, then I want this person to make my medical decisions.

(first name)  (last name)
(street address)  (city)  (state)  (zip code)
(home phone number)  (work phone number)

Put an X next to the sentence you agree with.

☐ My health care agent can make decisions for me right after I sign this form.

☐ My health care agent will make decisions for me only after I cannot make my own decisions.

You may write down your health care choices on this form. How do you want your health care agent to follow these choices? Put an X next to the one sentence you most agree with.

☐ I want my health care agent to work with my doctors and to use her/his best judgment. It is OK for my agent to follow my health care choices on this form as a general guide.

☐ Even though it is OK to follow my choices as a general guide, there are some choices I do not want changed:

To make your own health care choices, go to Part 2 on the next page.

To sign this form, go to Part 3 on page 9.
ប៉ុន្មានក្រមរបេះបញ្ជាក់១២ ពេញមុំនឺងជាក្រមរបេះបញ្ជាក់មានល្វែងចិត្តមកសម្រួលរមូលការណ៍

PART 2 Make your own health care choices

ប៉ុន្មានក្រមរបេះបញ្ជាក់មានល្វែងចិត្តមកសម្រួលរមូលការណ៍

ប៉ុន្មានក្រមរបេះបញ្ជាក់មានល្វែងចិត្តមកសម្រួលរមូលការណ៍

៖ ប្រការសករើសរើតការព្យាយាមរកសាអ្នក

My life is only worth living if I can:

☐ ឬទាក់ទងប៊ុន្មានក្រមរបេះបញ្ជាក់ ប្រភេទនៃការស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ី

Put an X next to all the sentences you most agree with.

☐ កុម្មត់ការសករើសរើតការព្យាយាមរកសាអ្នក ប្រភេទនៃការស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ី

My life is always worth living no matter how sick I am.

៖ ប្រការសករើសរើតការព្យាយាមរកសាអ្នក ឬទាក់ទងម្នេទាល់ស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ី

If I am dying, it is important for me to be:

☐ នៅជាមួយក្រមរបេះបញ្ជាក់ ប្រភេទនៃការស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ី

My life is always worth living no matter how sick I am.

៖ ប្រការសករើសរើតការព្យាយាមរកសាអ្នក ឬទាក់ទង្រឹមម្នេទាល់ស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ី

Is religion or spirituality important to you?

☐ ឬ ម្នេទាល់ស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ី

If you have one, what is your religion?

៖ ប្រការសករើសរើតការព្យាយាមរកសាអ្នក ឬទាក់ទង្រឹមម្នេទាល់ស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ី

What should your doctors know about your religion or spirituality?

ប្រការសករើសរើតការព្យាយាមរកសាអ្នក ឬទាក់ទង្រឹមម្នេទាល់ស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ីបស៊ី

If you are sick, your doctors and nurses will always try to keep you comfortable and free from pain.
Try all life support treatments that my doctors think might help.

If the treatments do not work and there is little hope of getting better, I want to stay on life support machines.

Try all life support treatments that my doctors think might help but not these treatments. Mark what you do not want.

CPR
feeding tube
Dialysis
Blood transfusion
Breathing machine
Medicine
Other treatments

Do not want any life support treatments.

Want my health care agent to decide for me.

I am not sure.
Put an X next to the one choice you most agree with.

**Donating (giving) your organs can help save lives.**

- [ ] I want to donate my organs.
- [ ] Which organs do you want to donate?
  - [ ] any organ
  - [ ] ____________________________
- [ ] I do not want to donate my organs.
- [ ] I want my health care agent to decide.
- [ ] I am not sure.

**An autopsy can be done after death to find out why someone died. It is done by surgery. It can take a few days.**

- [ ] I want an autopsy.
- [ ] I do not want an autopsy.
- [ ] I want an autopsy if there are questions about my death.
- [ ] I want my health care agent to decide.
- [ ] I am not sure.

What should your doctors know about how you want your body to be treated after you die?
ប្រការនេះទំព័របើកការបាន អ្នកកត្តរូវថត:

- ចុះហត្ថសលខាកដាេបំសពញ (sign this form)
- មានស្ក្សដីពដីរនាក់ ចុះហត្ថសលខាកដាេបំសពញ (have two witnesses sign the form)

ប្រការនេះមិនអាច ស្រការ ដីស្ធារណៈកត្តរូវថតចុះហត្ថសលខាស្មាះទាំព័របនាទាំព័របនាថ់។

ស្ក្សដីរបេ្ុសម្រាប់អ្នកយកកកដាេបំសពញសនះសៅស្រការដីស្ធារណៈ និងឲ្យសគចុះហត្ថសលខាសៅទំពវ័របនាទាំព័របនាថ់។

If you do not have witnesses, take this form to a notary public and have them sign on page 11.

PART 3 Sign the form

- សេចក្ដីបង្ គា ប់ថែទាំេុខភាពជាមុន រដ្ឋកាលដីហ្វ័រនដីញ៉ា (California Advance Health Care Directive)
ព្រលិត្យ 3: ដើរគន់សម្រាប់បង្ហោះបញ្ចូលការប្រឈមការសម្រាប់មនុស្ស

Part 3: Sign the form

Have your witnesses sign their names and write the date

បញ្ហាការរីករាលដន្លេ៖ ឬស្រូបការសម្រាប់មនុស្ស។

Have your witnesses sign their names and write the date

By signing, I promise that ______________________ signed this form while I watched.

១ រដ្ឋការរីករាលដន្លេ ឬកម្មការសម្រាប់មនុស្ស។

He/she was thinking clearly and was not forced to sign it. I also promise that:

• ឬបានបញ្ហាធិបតេយ្យាឥ្មុណ្ដករូបរបេំសពញសនះ ក្នុងកាលបានសមើល។

By signing, I promise that ______________________ signed this form while I watched.

២ រដ្ឋការរីករាលដន្លេ ឬកម្មការសម្រាប់មនុស្ស។

He/she was thinking clearly and was not forced to sign it. I also promise that:

• ឬបានបញ្ហាធិបតេយ្យាឥ្មុណ្ដករូបរបេំសពញសនះ ក្នុងកាលបានសមើល។

By signing, I promise that ______________________ signed this form while I watched.

២ រដ្ឋការរីករាលដន្លេ ឬកម្មការសម្រាប់មនុស្ស។

He/she was thinking clearly and was not forced to sign it. I also promise that:

• ឬបានបញ្ហាធិបតេយ្យាឥ្មុណ្ដករូបរបេំសពញសនះ ក្នុងកាលបានសមើល។

By signing, I promise that ______________________ signed this form while I watched.
CERTIFICATE OF ACKNOWLEDGEMENT OF NOTARY PUBLIC

State of California
County of ____________

On ____________ before me, ________________________________, personally appeared

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.

______________________________  ________________________________
Signature   Signature of Notary Public

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<tr>
<th>Description of Attached Document</th>
<th>RIGHT THUMBPRT OF SIGNER</th>
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<td>Title or Type of document:</td>
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<td>Date: __________________________</td>
<td>(Notary Seal)</td>
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<td>Number of pages: ________________</td>
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Capacity(ies) Claimed by Signer(s)

☐ Individual
☐ Guardian or conservator
☐ Other ________________________________
Give this form to your nursing home director only if you live in a nursing home.

California law requires nursing home residents to have the nursing home ombudsman as a witness of advance directives.

STATEMENT OF THE 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."

(sign your name) / (date)

(print your first name) (print your last name)

(street address) (city) (state) (zip code)