

Jewish Advance Healthcare Directive

An easy-to-use form to make your goals, values and preferences known



CEDARS-SINAI®



Why Should You Have an Advance Healthcare Directive?

Whether you are young, old, healthy or sick, it is important to plan ahead and clearly state your healthcare goals, values and preferences. An Advance Healthcare Directive (“directive”) is the best place to do this. Your completed directive will give you greater peace of mind and provide comfort and guidance to the people in your life who may, at some point, be asked to speak on your behalf.

The process of filling out your Directive may help you talk with loved ones and your Rabbi about what matters most to you. There are also a number of resources available at Cedars-Sinai to help you complete your directive, including social workers, spiritual care experts and a free Advance Care Planning class. For information on these and other resources, please see the back cover of this document.

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PART 1:

My Healthcare Agent and Rabbi

SECTION A CHOOSING MY HEALTHCARE AGENT

- For help with filling out this section, please refer to pages 3-4 of the Step-by-Step Guide.
-

I choose the following person to speak on my behalf if at any time I am not able to (or choose not to) express my own goals, values and preferences:

Name: _____

Relationship to You: _____

Phone Number(s): _____

Email Address (if known): _____

The following person(s) can serve as alternate agents (this is optional):

First Alternate

Name: _____

Relationship to You: _____

Phone Number(s): _____

Email Address (if known): _____

Second Alternate

Name: _____

Relationship to You: _____

Phone Number(s): _____

Email Address (if known): _____

PART 1:

My Healthcare Agent and Rabbi

SECTION B CHOOSING A RABBI

- For help with filling out this section, please refer to pages 5 of the Step-by-Step Guide.
-

As a Jew, it is my desire, and I hereby direct, that all decisionmaking about my healthcare be done in accordance with Jewish law and custom.

- ☐ *To determine the requirements of Jewish law and custom, I further direct my agent to consult with the following Rabbi:*

Rabbi

Name: _____

Phone Number(s): _____

Email Address (if known): _____

Street Address (if known): _____

City, State, Zip Code (if known): _____

If such Rabbi is unable, unwilling or unavailable to provide such consultation and guidance, I direct my agent to consult with the following Rabbi or Rabbi referred by the institution or organization:

Alternate Rabbi/Institution

Name: _____

Name of Institution/Organization: _____

Phone Number(s): _____

Email Address (if known): _____

Street Address (if known): _____

City, State, Zip Code (if known): _____

Part 1 (continued)

If such institution or organization is unable, unwilling or unavailable to make such a referral, or if the Rabbi referred by such institution or organization is unable, unwilling or unavailable to provide such guidance, then I ask my agent to consult with a Rabbi whose guidance on issues of Jewish law and custom my agent in good faith believes I would respect and follow.

SECTION C

WHEN WOULD I LIKE MY HEALTHCARE AGENT TO BEGIN REPRESENTING ME?

- For help with filling out this section, please refer to page 5 of the Step-by-Step Guide.

Please complete the sentence below by initialing either option 1 or option 2:

I would like my healthcare agent to begin participating in decisionmaking about my healthcare...

Option 1

...only when my physician determines that I am unable to express my own goals, values and preferences.

(Initial Here)

Option 2

...from this time forward, even if I am still able to speak for myself.

(Initial Here)

PART 2:

My Healthcare Goals, Values and Preferences

SECTION A

QUALITY OF LIFE (I.E. WHAT MATTERS MOST IN THE FACE OF SEVERE ILLNESS)

- For help with filling out this section, please refer to pages 6-10 of the Step-by-Step Guide.

Life is a central value for Jews. Accordingly, under no circumstances does Jewish Law permit death to be actively hastened when one is ill. Indeed, Jewish Law usually forbids the withdrawal of life sustaining interventions if such withdrawal will likely result in death occurring in a relatively brief time span. Jewish Law also usually requires that food and fluids be provided (unless doing so causes harm or will hasten death). Jewish Law does not always demand, however, that life-sustaining interventions be initiated in all circumstances. Determining when it may be permissible to withhold medical interventions, including life-sustaining interventions, and even if such interventions may be withdrawn, requires input from a Rabbi. Providing proper care for a patient, often requires that one's Rabbi and medical team know what matters most to the patient.

This section allows you to share what matters to you. This information will help everyone better understand who you are and what is most important to you even in the face of severe illness. This can be a challenging topic – it can make you think about questions such as “what makes my life worth living?,” “what do I value most about my mental and physical health?” and “how much pain and suffering would I prefer to (or not to) endure if I am determined to be terminally ill (as defined pursuant to Jewish law)?”

After reviewing and completing the questionnaire on pages 6-10 of the Step-by-Step Guide which correspond with this section of your Advance Healthcare Directive, please describe your values by completing the following sentence:

Having thought about what matters to me in terms of my religious commitments, my physical and bodily functioning, and cognitive, interactive, social, and community dimensions of my life, in the event of severe terminal illness my life would be worth living, and therefore I would want medical treatments to be initiated, under the following circumstances (i.e. What is the minimal accepted condition that I would nevertheless want to have my life prolonged for?):

If you would like to share additional details, please use page 7 or the extra pages provided at the end of this document.

SECTION B SCOPE OF TREATMENT

■ For help with filling out this section, please refer to pages 11-12 of the Step-by-Step Guide.

Some people have ideas about which treatments they would be willing to receive and which ones they would not accept under any circumstances. Consultation with a rabbi is crucial for specific determinations, but this section is designed to help you communicate some of those preferences, if you have them.

☐ If my physician believes that I do not have a reasonable chance of recovering to the minimal Quality of Life I stated in Part 2A (on the previous page), I would not want the following procedures initiated:

OR

☐ I want ALL procedures, treatments and interventions possible to prolong my life.

OR

☐ I am not sure.

If you would like to share additional details, please use page 7 or the extra pages provided at the end of this document.

SECTION C FURTHER EXPLANATION (OPTIONAL)

If you would like to share more thoughts and information to help others understand you better, you may do so here. Please share a bit about your own values and healthcare preferences, how invasive treatments can be and still be acceptable to you, and any other concerns you may have about treatment (not only at the end of life). Please also include any preferences you may have about where, and with whom, you would want to be at the end of your life (i.e. in a healthcare facility, at home, etc.), as well as your conception of a “good death” or a “bad death.” You may also want to simply finish this sentence: “What matters to me at the end of life is ____”

This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

If you would like to share additional details, please use the extra pages provided at the end of this document.

PART 3:

How Strictly Do I Want My Advance Healthcare Directive Followed?

- For help with filling out this section, please refer to page 13 of the Step-by-Step Guide.
-

Please complete the sentence below by initialing either option 1 or option 2:

I want my goals, values and preferences, as expressed in this directive...

Option 1

...to serve as a general guide.

(Initial Here)

Option 2

... to be followed strictly, under all circumstances.

(Initial Here)

PART 4 (OPTIONAL): Additional Preferences

- For help with filling out this section, please refer to page 14 of the Step-by-Step Guide.

Cadaveric Organ Donation

This section is relevant only if death has been determined as defined by Jewish Law and custom in consultation with my Rabbi.

- ☐ I wish to donate any and all organs and tissues.

OR

- ☐ I do not wish to donate any of my organs or tissues.

OR

- ☐ I wish to donate only the following organs or tissues (please specify):

My Wishes for After I Die

- ☐ All decisions concerning the handling and disposition of my body and preparation for burial are to be made pursuant to Jewish law and custom as determined by my designated Rabbi. Prior to contacting my designated Rabbi, unless there is prior specified authorization by the Rabbi, it is my desire, and I hereby direct, that no post-mortem procedure be performed on my body (e.g. subject to certain limited exceptions, Jewish law generally prohibits the performance of any autopsy).

I have the following wishes regarding funeral and burial arrangements:

If you would like to share additional details, please use the extra pages provided at the end of this document.

Part 4 (continued)

PART 5 (OPTIONAL): Identifying My Physician

- For help with filling out this section, please refer to page 14 of the Step-by-Step Guide.

You may have physicians involved in your care who understand your goals, values and preferences. If you would like them to be involved in discussions regarding your condition and treatment options, please list their names and contact information below.

Name of Physician: _____

Phone Number(s) (if known): _____

Email Address (if known): _____

Name of Physician: _____

Phone Number(s) (if known): _____

Email Address (if known): _____

Name of Physician: _____

Phone Number(s) (if known): _____

Email Address (if known): _____

Please remember also to discuss your values and choices with the physician(s) named above and provide him/her/them a copy of your directive.



PART 6:

Signing My Advance Healthcare Directive

- For help with filling out this section, please refer to page 15 of the Step-by-Step Guide.
-

In order to make this document legal and valid, you must sign below. Your signature must be witnessed by either a **notary public** (Option 1, see page 14) or in the presence of **two witnesses** (Option 2, see page 15):

Name (Print):

Signature:

Date of Signature:

OPTION 1: Signing My Advance Healthcare Directive With a Notary

NOTARIZATION

(California All-Purpose Acknowledgment, Civil Code 1189)

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.

State of California

County of _____

}

On _____ before me, _____
Date Here Insert 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.

Signature _____
Signature of Notary Public

.....
Place Notary Seal Above

OPTION 2: Signing My Advance Healthcare Directive With Witnesses

STATEMENT OF WITNESSES

I declare under penalty of perjury under the laws of California 1) that the individual who signed or acknowledged this Advance Healthcare 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 Healthcare 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 Healthcare Directive; and 5) that I am not the individual's healthcare provider, an employee of an operator of a community care facility, nor the employee of an operator of a residential care facility for the elderly; and 6) I am over 18 years of age.

WITNESS #1

Signature of Witness #1

Date

Printed Name of Witness #1

Phone Number

WITNESS #2

Signature of Witness #2

Date

Printed Name of Witness #2

Phone Number

One of the witnesses also must 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 Healthcare 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.

Signature of Witness #1 or #2

Date

Special Witness Requirement

Note: For nursing home or skilled nursing facility patients only, a signature from a patient advocate or ombudsman is required in addition to completing either page 14 or 15.

If you are **not** in a nursing home or skilled nursing facility, you may skip this section.

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.

Signature of Patient Advocate or Ombudsman

Date

Printed Name of Patient Advocate or Ombudsman

Phone Number

[illegible]

[illegible]

Additional Resources

To sign up for the free Advance Care Planning Class, call 800-700-6424.

Cedars-Sinai Supportive Care Medicine, 310-423-9520

Cedars-Sinai's Supportive Care Medicine (SCM) team helps inpatients and outpatients who are facing life-limiting or advanced illness to achieve the best possible quality of life, and also provides support for families. SCM clinicians are experts in managing a full range of symptoms, both physical and psychological; they are also specifically trained to help with Advance Care Planning and Advance Healthcare Directives.

Cedars-Sinai Spiritual Care, 310-423-5550; cedars-sinai.edu/spiritualcare

Members of the Cedars-Sinai Spiritual Care Department offer spiritual care services to Cedars-Sinai patients and their loved ones. Chaplains are available to visit patients and help work through difficult issues related to end-of-life decisions and care.

Cedars-Sinai Center for Healthcare Ethics, 310-423-9636; cedars-sinai.edu/ethics

For patients hospitalized at Cedars-Sinai Medical Center, the center offers clinical ethics consultation. The aim is to help patients, family members, physicians and other members of the patient care team examine and discuss pertinent ethical values and goals.

Cedars-Sinai Social Work

Inpatient: 310-423-4446 | Outpatient: 310-248-8311

The following are some websites that provide information on advance healthcare planning:

- Advance Health Care Directive Registry — California; sos.ca.gov/registries/advance-health-care-directive-registry
- Aging With Dignity; agingwithdignity.org
- American Hospital Association; putitinwriting.org
- California Medical Association; cmanet.org
- Caring Connections; caringinfo.org
- Coalition for Compassionate Care of California; coalitionccc.org and capolst.org (POLST forms in English and other languages)
- Hospice Association of America; hospice.nahc.org
- Donate Life California – Organ and Tissue Donor Registry; donatelifecalifornia.org
- U.S. Department of Veterans Affairs; www.losangeles.va.gov/patients/advance.asp

Please send a copy of your signed, completed Advance Healthcare Directive to:

Fax: 310-248-8078 | Email: groupMNSHID@cshs.org



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