Advance Directive for **Health Care**
*（用于*医疗保健的*预设指示）*

Respecting Your Right To:

（尊重您的以下权利：）

Choose Your Health Care Agent
（选择您的医疗保健代理人）

Choose the Authority Given to Your Health Care Agent
（选择授予您的医疗保健代理人的权限）

Choose Your Preferences Related to Treatment & Care
（选择与治疗和护理相关的偏好）

Printed Name （工整填写姓名）

Birthdate （出生日期）

Name: （姓名：） _____

Getting Oriented （确立导向）

PART ONE- Choose a Health Care Agent (the person(s) you choose to make health care decisions for you when needed).
[**第一部分** - 选择医疗保健代理人（您所选择的必要时为您做出医疗保健决定的人）。]

PART TWO- Select some medical treatment preferences.
（**第二部分** - 选择一些医疗偏好。）

PART THREE- Guidance for your Health Care Agent
（**第三部分** - 对您的医疗保健代理人作出的指示）

PART FOUR (Required)- Your signature and two witnesses.
[**第四部分（必填）**- 您的签名和两名见证人。]

You may fill out Part One, Part Two, or both, but if you have filled out ANY section of this form then Part Four MUST be filled in to make it legally valid.
（您可以填写第一部分、第二部分，或者两个部分，但如果您已经填写了本表的**任何**部分，则必须填写第四部分，以使其具有法律效力。）

Explanation and Directions for this Advance Directive: （本预设指示的解释和说明：）

This document goes into effect only when you are unable to (or choose not to) make health care decisions for yourself.
[本文件仅在您无法（或选择不）为自己做出医疗保健决定时生效。]

1. This is an important legal document.
（这是一份重要的法律文件。）
2. This is a way to communicate health care preferences to your health care providers and others who care about you (e.g. friends, family).
[这是向您的医疗保健提供者和其他照护您的人（例如朋友、家人）传达医疗保健偏好的一种方式。]
3. This document does NOT give permission for your health care agent to make business or financial decisions on your behalf
（本文件**不**允许您的医疗保健代理人代表您做出商务或财务决策）

Steps to Take After Completing This Advance Directive: （完成本预设指示后采取的步骤：）

1. Talk about your advance directive and your health care related goals and preferences with:
（与以下人员讨论您的预设指示以及您的医疗保健相关目标和偏好：）
   - ❑ Your Health Care Agent and Backup Agent
（您的医疗保健代理人和备用代理人）
   - ❑ Your Friends
（您的朋友）
   - ❑ Your Family
（您的家人）
   - ❑ Your Emergency Contact
（您的紧急联系人）

2. Give copies of your advance directive to: （向以下人员提供您的预设指示副本：）
   - ❑ Your Health Care Agent（您的医疗保健代理人）
   - ❑ Your Backup Health Care Agent （您的备用医疗保健代理人）
   - ❑ Your health care providers（您的医疗保健提供者）

3. Keep a copy of your advance directive where it can easily be found (e.g. on the refrigerator).
[将您的预设指示的副本放在容易找到的地方（例如冰箱上）。]

4. If you are going to the hospital or a nursing home, take a copy of this document with you and ask that it be placed in your medical records.
（如果您要去医院或疗养院，请随身携带这份文件的副本，并要求将其放入您的医疗记录中。）

Remember: You may revoke this completed form (advance directive) at any time by:
[**请记住：**您可以随时通过以下方式撤销此份已填毕的表格（预设指示）：]

1. Completing a written statement declaring your preference to revoke that is signed and dated; OR
   （完成一份书面声明，声明您希望撤销，并签名及注明日期；**或者**）
2. Stating your desire to revoke the document in the presence of a witness 18 years of age or older who completes a written statement of your expression within 30 days of your declaration. The statement should be signed and dated; AND
   （说明您希望在一位 18 岁或以上见证人在场的情况下撤销该文件，该见证人会在您作出声明后的 30 天内完成一份您表达的书面陈述。该声明应签名并注明日期；**以及**）
3. Communicating the revocation to your attending physician and other health care providers.
   （与您的主治医生和其他医疗保健提供者沟通，以撤销您的预设指示。）

How Often Should You Consider Making Changes to Your Advance Directive?
（您应该多久考虑更改您的预设指示？）

It is good to review and update your advance directive when one of the following occurs:
（当出现以下任一情况时，最好查看并更新您的预设指示：）

- ❑ *Decade*- at the start of a new decade of your life (every 10 years)
  [*十年* - 人生新十年伊始（每 10 年）]
- ❑ *Death*- if your health care agent dies or if your choices have changed after the death of a loved one
  （*死亡* - 如果您的医疗保健代理人去世或在亲人去世后您的选择有所变化）
- ❑ *Divorce*- if you marry someone other than your health care agent or if you divorce your healthcare agent, then this document is automatically revoked
  （*离婚* - 如果您与您的医疗保健代理人以外的人结婚，或者如果您与您的医疗保健代理人离婚，此文件将自动撤销）
- ❑ *Diagnosis*- if you are diagnosed with a chronic or serious illness
  （*诊断* - 如果您被诊断患有慢性或严重疾病）
- ❑ *Decline*- if your health gets worse over time, especially if you are no longer able to live on your own.
  （*衰退* - 如果您的健康状况随着时间的推移而恶化，尤其是当您不再能够独自生活时）

Need help completing this document? （需要帮助完成此文件？）
Contact a Respecting Choices advance care planning facilitator at **wellstar.org/acp** to ask a question.
[请联系 **wellstar.org/acp** 上的 Respecting Choices （尊重选择）预设护理规划协调员咨询问题。]

PART ONE: My Choice for Health Care Agent （第一部分：我选择的医疗保健代理人）

(Part 1 will be effective even if Part 2 is not completed)
（即使第 2 部分未完成，第 1 部分也将生效）

Who Should You Choose as Your Health Care Agent? （您应该选择谁担任您的医疗保健代理人？）

- Someone who knows you well, and will respect your goals and values（熟悉您并尊重您的目标和价值观的人）
- Someone you trust to make decisions in difficult circumstances（您所信任的能够在困难的情况下做出决定的人）
- Someone who will be a good advocate for you and follow your decisions, even if he/she may not agree with them（即使他/她可能不同意这些决定，也会坚决拥护您并遵循您的决定的人）
- Someone 18 years or older（18 岁或以上的人）

Who Cannot Be Your Health Care Agent? （谁不能担任您的医疗保健代理人？）

- A health care provider if he/she is directly involved in your care（医疗保健提供者，如果他/她直接参与您的护理）
- Someone younger than 18 years old（18 岁以下的人）

If I can no longer make my own health care decisions (or I choose not to), this directive names the person I authorize to make these choices on my behalf; even if I do not fill out my treatment preferences in the next part. This person will be my health care agent.
[如果我不能再做出自己的医疗保健决定（或我选择不做决定），此指示指定了我授权代表我做出这些选择的人；即使我没有在下一部分填写我的治疗偏好，此人也将成为我的医疗保健代理人。]

The Person I Choose as My Health Care Agent: （我选择担任我的医疗保健代理人的人）

Name （姓名） _____ Relationship （关系） _____

Telephone (Cell) 电话（手机） _____ (Work) （工作） _____ (Home) （住宅） _____

Address （地址） _____

Email Address (optional) [电子邮件地址（可选）] _____

If my health care agent cannot be contacted within a reasonable time period or for any reason is unable or unwilling to act as my health care agent, then I select the following back up health care agents to be contacted in order of choice.
（如果无法在合理的时间内联系到我的医疗保健代理人，或者由于任何原因，其无法或不愿意担任我的医疗保健代理人，那么我选择按照以下顺序联系我的备用医疗保健代理人。）

Back-Up Agent # 1: （备用代理人一）

Name （姓名） _____ Relationship （关系） _____

Telephone (Cell) 电话（手机） _____ (Work) （工作） _____ (Home) （住宅） _____

Address （地址） _____

Email Address (optional) [电子邮件地址（可选）] _____

Back-Up Agent # 2: （备用代理人二）

Name （姓名） _____ Relationship （关系） _____

Telephone (Cell) 电话（手机）_____ (Work) （工作） _____ (Home) （住宅） _____

Address （地址） _____

Email Address (optional) [电子邮件地址（可选）] _____

❑ **By checking this box, I'm indicating that I do not have a health care agent. Instead, please allow my selections on Part Two to guide my health care decisions.**

（选中此框表示我没有医疗保健代理人。取而代之，请允许按照我在第二部分的选择来指导我的医疗决定。）

What My Health Care Agent Can Do: （我的医疗保健代理人可以做什么：）

I understand that I have chosen a health care agent to make decisions for me related to my health care. He/she will have the same authority to make any health care decision that I could make. For example:
（我了解，我已选择医疗保健代理人为我做出与我的医疗保健相关的决定。他/她将拥有相同的权力来做出我可以做出的任何医疗保健决定。例如：

- Take my instructions and what he/she knows of my preferences/values to act in my best interest.
（听从我的指示以及他/她对我的偏好/价值观的了解，采取符合我最大利益的行动。）
- Authorize, request, refuse, withdraw, and/or withhold any and all types of medication, treatment, procedures or health care.
（授权、请求、拒绝、撤回和/或扣留任何和所有类型的药物、治疗、程序或医疗保健。）
- Consent, negotiate and/or contract for any health care facility or service for me, such as assisted living, skilled nursing facility, hospital, hospice or nursing home. These actions will not make my health care agent liable to pay for these services.（为我同意、协商和/或签约任何医疗保健机构或服务，例如辅助生活设施、专业护理设施、医院、临终关怀或疗养院。这些行为并不会使我的医疗保健代理人负有为这些服务付费的责任。）
- Review and release my medical records as needed for my medical care.
（根据我的医疗护理需要查看和披露我的医疗记录。）

Note: Under Georgia law, a court can take away the powers of your health care agent if it finds he/she is not acting in accordance with your preferences. Your health care agent DOES NOT have the power to make decisions regarding behavioral treatment, sterilization, treatment or involuntary hospitalization for mental or emotional illness, or addictive disease.
（注：根据佐治亚州法律，如果法院认定您的医疗保健代理人没有按照您的偏好指示行事，法院可以剥夺其权力。您的医疗保健代理人无权就精神或心理疾病、或成瘾性疾病做出行为治疗、绝育、治疗或非自愿住院等方面的决定。）

What My Health Care Agent Can Do After I Die: （我的医疗保健代理人在我去世后可以做什么：）

I understand that my health care agent can make decisions about the following (unless I have initialed to indicate I do not want him/her to have that authority/ability):
[我了解，我的医疗保健代理人可以就以下事项做出决定（除非我已以姓名首字母签名以表明我不希望其拥有该权限/能力）：]

1. **Autopsy-** *My health care agent WILL have the power to authorize (give permission) for an autopsy*
   [**尸检 -** *我的医疗保健代理人**将**有权授权（允许）进行尸检*]
2. **Organ Donation and/or Body Donation-** *My health care agent WILL have the power to donate my body for use in a medical study and/or donate any of my organs*
   （**器官捐赠和/或身体捐赠 -** *我的医疗保健代理人**将**有权捐赠我的身体用于医学研究和/或捐赠我的任何器官*）
3. **Final Disposition of My Body-** *My health care agent WILL have the power to authorize the final disposition of my body including funeral arrangements and burial or cremation*
   （**我的身体的最终处置 -** *我的医疗保健代理人**将**有权授权对我的身体进行最终处置，包括葬礼安排和埋葬或火化*）

Only initial those things that you DO NOT want your health care agent to be able to do after you die
（仅以姓名首字母签名，以表明您不希望您的医疗保健代理人在您去世后能够做的事情）

1. **Autopsy:** _____ (Initial) I do NOT give the authority to my health care agent to authorize an autopsy (unless required by law).
   [**尸检：**_____ （姓名首字母签名）我**没有**授权我的医疗保健代理人授权进行尸检（除非法律要求）。]

2. **Organ Donation and Body Donation: （器官捐赠和身体捐赠：）**

   a. _____ (Initial) I do NOT give authority to my health care agent to donate my body for use in a medical study.
   [（姓名首字母签名）我**没有**授权我的医疗保健代理人捐赠我的身体用于医学研究。]

   b. _____ (Initial) I do NOT give authority to my health care agent to donate any of my organs.
   [（姓名首字母签名）我**没有**授权我的医疗保健代理人捐赠我的任何器官。]

3. **Final Disposition of My Body**: _____ (Initial) I do NOT give authority to my health care agent to make decisions about final disposition of my body.
   [**我身体的最终处置：**_____ （姓名首字母签名）我**没有**授权我的医疗保健代理人就我的身体的最终处置做出决定。]

   I want the following person to make decisions about the final disposition of my body:
   （我希望以下人员对我身体的最终处置做出决定：）

   Name （姓名）_____ Phone （电话） _____

   Address （地址）_____

   Initial your preference for the final disposition of your body:
   （以姓名首字母签名，确认您对身体最终处置的偏好：）

   _____ (Initial) I want to be buried.
   [（姓名首字母签名）我想要土葬。]

   _____(Initial) I want to be cremated.
   [（姓名首字母签名）我想要火化。]

PART TWO: My Treatment Preferences （第二部分：我的治疗偏好）

(Part 2 will be effective even if Part 1 is not completed)

（即使第 1 部分未完成，第 2 部分也将生效）

This is your opportunity to make your preferences clear. Your health care agent and your doctors will refer to this section as a guide when you cannot make informed decisions. If you did NOT name a health care agent or back-up agent or if he/she cannot be reached, you can direct your care with the choices you indicate below. **WITH ANY CHOICE BELOW**, I understand I will be kept clean and comfortable and continue to receive medications for pain control and comfort.

（您可以在这部分明确您的偏好。当您无法做出知情决定时，您的医疗保健代理人和您的医生将参考本部分作为指导。如果您**没有**指定医疗保健代理人或备用代理人，或者如果无法联系到您的医疗保健代理人，您可以使用您在下面指出的选择来指示您的医疗护理。**通过在下面做出的任何选择**，我了解我将保有清洁和舒适度，并继续接受药物来控制疼痛和获得安慰。）

Initial each statement you choose as your treatment preferences if you are in these situations:
（如果您处于这些情况，请在您选择作为治疗偏好的每条陈述的前面以姓名首字母签名：）

If I have a **terminal illness** (incurable or irreversible condition) and my attending physician and another physician believe (and write in the medical record) that I will die within a short period of time, this is my choice:
[如果我患有**绝症**（无法治愈或不可逆转的疾病）并且我的主治医生和另一位医生认为（并在医疗记录中写下）我将在短时期内去世，则此项是我的选择：]

1. _____ **I want to extend my life for as long as possible** using all treatments that the doctors believe are reasonable. Some examples are a machine that breathes for me (respirator/ventilator), feeding tubes, blood products, medications, and/or fluids given to me through an IV or treatments for chronic medical conditions. （**我想**使用医生认为合理的所有治疗方法，**尽可能延长我的生命**。示例包括：使用人工替代呼吸的机器（呼吸器/呼吸机）、喂食管、血液制品、药物和/或静脉输液，或慢性疾病治疗。）

OR（或者）

2. _____ **I want to allow my natural death** to occur by refusing or stopping all treatments except any I choose below: （**我想**通过拒绝或停止所有治疗来**让我自然死亡**，但是我在下面选择的任何治疗除外）

   a. _____ If I cannot get nutrition by mouth, I want to receive nutrition by tube/other medical means.
   （如果我不能经口摄入营养，我想通过管道/其他医疗方式获得营养。）

   b. _____ If I cannot drink fluids by mouth, I want to receive fluids by tube/other medical means.
   （如果我不能经口摄入液体，我想通过管道/其他医疗方式接受液体。）

   c. _____ If I need assistance to breathe, I want to have a ventilator/respirator used.
   （如果我需要呼吸帮助，我想使用呼吸机/呼吸器。）

   d. _____ If my heart or pulse has stopped, I want to have cardiopulmonary resuscitation (CPR) used.
   [如果我的心脏或脉搏停止，我想进行心肺复苏术 (CPR) 。]

If I am in a **state of permanent unconsciousness** (an incurable or irreversible condition) in which my attending physician and another physician believe (and write in the medical record) that I am not expected to recover the ability to know who I am, who my friends and family are or where I am, this is my choice:
[如果我处于**永久昏迷状态**（一种无法治愈或不可逆转的状况），并且我的主治医生和另一位医生认为（并写在医疗记录中）预计我不会恢复知道我自己是谁、我的朋友和家人是谁、或者我在哪里的能力，则此项是我的选择：]

1. _____ **I want to extend my life for as long as possible** using all treatments that the doctors believe are reasonable. Some examples are a machine that breathes for me (respirator/ventilator), feeding tubes, blood products, medications, and/or fluids given to me through an IV or treatments for chronic medical conditions. [**我想**使用医生认为合理的所有治疗方法，**尽可能延长我的生命**。示例包括：使用人工替代呼吸的机器（呼吸器/呼吸机）、喂食管、血液制品、药物和/或静脉输液，或慢性疾病治疗。]

OR（或者）

2. _____ **I want to allow my natural death** to occur by refusing or stopping all treatments except any I choose below: （**我希望**通过拒绝或停止所有治疗**让我自然死亡**，但是我在下面选择的任何治疗除外：）
   a. _____ If I cannot get nutrition by mouth, I want to receive nutrition by tube/other medical means.
   （如果我不能经口摄入营养，我想通过管道/其他医疗方式获得营养。）
   b. _____ If I cannot drink fluids by mouth, I want to receive fluids by tube/other medical means.
   （如果我不能经口摄入液体，我想通过管道/其他医疗方式接受液体。）
   c. _____ If I need assistance to breathe, I want to have a ventilator/respirator used.
   （如果我需要呼吸帮助，我想使用呼吸机/呼吸器。）
   d. _____ If my heart or pulse has stopped, I want to have cardiopulmonary resuscitation (CPR) used.
   [如果我的心脏或脉搏停止，我想进行心肺复苏术 (CPR) 。]

My additional preferences and wishes regarding my health care: （我对医疗保健的其他偏好和愿望）

Attach Additional pages about treatment preferences (signed and dated) as needed
[根据需要附上关于治疗偏好的附加页面（签名并注明日期）]

PART THREE: Binding Guidance for Health Care Agent
（第三部分：对医疗保健代理人的约束性指示）

When making health care decisions for me, my health care agent must think about what action would be consistent with past conversations we have had, my treatment decisions as expressed in PART TWO, my religious and other beliefs and values I hold, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my health care agent should make decisions for me that he/she believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

（在为我做出医疗保健决定时，我的医疗保健代理人必须考虑哪些行动与我们过去的对话、我在**第二部分**中表达的治疗决定、我的宗教信仰和其他信仰及价值观、我过去处理医疗和其他重要问题的方式相一致。如果我的决定仍然不清楚，我的医疗保健代理人则应该为我做出其认为符合我最大利益的决定，同时考虑到我目前的情况和治疗方案的益处、负担和风险。）

If I have appointed a health care agent who gives instructions that differ from my treatment preferences in PART TWO of this Advance Directive, then I direct that (**Initial only one of the following**):

[如果我指定的医疗保健代理人做出的指示与我在本预设指示**第二部分**中的治疗偏好不同，那么我会指示（**仅选择一项并以姓名首字母签名**）：]

(Initial) （姓名首字母签名） _____	Follow Advance Directive: This Advance Directive will override instructions my Health Care Agent gives about prolonging my life. （遵循预设指示：本预设指示将优先于我的医疗保健代理人做出的关于延长我生命的指示。）
(Initial) （姓名首字母签名） _____	Follow my Health Care Agent: My Health Care Agent has authority to override this Advance Directive. （遵循我的医疗保健代理人：我的医疗保健代理人有权推翻本预设指示。）

PART FOUR: Making this Advance Directive Complete and Legally Valid
（第四部分：使本预设指令完整且具有法律效力）

Sign and date (or acknowledge signing and dating) this form in the presence of two witnesses. Both witnesses must be emotionally and mentally capable and at least 18 years of age, but the witnesses do not have to be together or present with you when you sign this form.

[在两名见证人在场的情况下签署此表格并注明日期（或确认签署和注明日期）。两位见证人均必须在心理和精神上健全，并且至少年满 18 岁，但是当您签署此表格时，见证人不必与您在一起或在场。]

A witness: （见证人：）

- Cannot be a person who was selected to be your health care agent or back-up agent(s)
  （不能是被选为您的医疗保健代理人或备用代理人的人）

- Cannot be a person who will gain financially from your death（不能是因您去世而获得经济利益的人）
- Cannot be a person who is directly involved in your health care（不能是直接参与您的医疗保健的人）

Only one of the witnesses may be an employee, agent or medical staff member of the hospital, skilled nursing facility, hospice or other health care facility in which you are receiving health care (but this witness cannot be directly involved in your health care).
[只有一名见证人可以是您接受医疗保健的医院、专业护理机构、临终关怀机构或其他医疗机构的雇员、代理人或医务人员（但该见证人不能直接参与您的医疗保健）。]

My Signature and Date （我的签名和日期）

This form revokes any advance directive for health care, durable power of attorney for health care, health care proxy, or living will that I have completed before the date indicated beside my signature. This form does not revoke an advance directive for behavioral health treatment.
（此表格撤销我在签名旁边所示日期之前已填写的任何医疗预设指示、长期有效的医疗授权书、医疗委托书或生前遗嘱。此表格不会撤销为行为健康治疗做出的预设指示。）

I am emotionally and mentally capable to make this advance directive and I understand its purpose and effect. I agree with everything written in this document and have completed this document of my free will.
（我在心理和精神方面健全，有能力做出此预设指示，并且我了解其目的和效力。我同意本文件中的所有内容，并自愿完成本文件。）

Signature (签名） _____ Date (日期） _____

My Witnesses （我的见证人）

The maker of this Advance Directive signed this form in my presence or acknowledged signing this form to me. I believe this person to be emotionally and mentally capable of making this advance directive. I am at least 18 years old and I signed this form willingly and voluntarily.
（本预设指示的制定者在我在场的情况下签署了此表格，或向我确认了签署此表格。我认为此人在心理和精神方面健全，能够做出此预设指示。我已年满 18 岁，自由且自愿签署此表格。）

Witness Number One: （见证人一）

Signature（签名） _____ Date（日期） _____

Printed Name of Witness（见证人的工整填写姓名） _____

Address（地址） _____

Witness Number Two: （见证人二）

Signature（签名） _____ Date（日期） _____

Printed Name of Witness（见证人的工整填写姓名） _____

Address（地址） _____

********This form DOES NOT need to be notarized（此表格不需要公证）********