8.1 Advance Health Care Directive – CA Hospital Association (Spanish version in Appendix)
8.2 How to Register Your Advance Directive
8.3 Advance Directive Form Registration
8.4 DMV Report Form
8.5 PREPARE™ for your care
8.6 Things My Loved Ones Need to Know
8.7 Tips from Geriatricians

Important Notes

• DMV Report Form is for reporting patients with lapses of consciousness or control, Alzheimer’s disease or other conditions which may impair the ability to operate a motor vehicle safely. A fillable form of this PDF is available at https://confidential-morbidity-report.pdffiller.com/ (Accessed August 31, 2017)
• PREPARE™ for your care has developed an easy 5-step process for completing an advance directive, as well as an easy-to-read version of the CA Advance Directive, which has been translated into 9 other languages. See the PREPARE website https://www.prepareforyourcare.org for more information, and all versions of Advance Directive are at http://www.iha4health.org/our-services/advance-directive/ (accessed August 15, 2017)
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.

Name of Patient: _____________________________________________________________

Date of Birth: ____________________________________________________________
**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 __________ Research __________
(Initial here) (Initial here)

Therapy __________ Education __________
(Initial here) (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 __________ No __________
   (Initial here) (Initial here)

2. My donated tissue may be used for applications outside of the United States.
   Yes __________ No __________
   (Initial here) (Initial here)

3. My donated tissue may be used by for-profit tissue processors and distributors.
   Yes __________ No __________
   (Initial here) (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) __________ (name(s) of signer(s)) ______________________ personally appeared ___________________________ 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: __________________________ [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: ____________________________________________

(03/17)  
Page 8 of 8  
California Hospital Association
How to Register Your Advance Directive

Step 1

A person who has executed an advance health care directive may register information regarding the directive with the Secretary of State. This information is made available upon request to the registrant's health care provider, public guardian, or legal representative. A request for information must state the need for the information.

You must first prepare and execute an advance health care directive. To obtain or create an advance health care directive:

- Contact your health care provider.
- Consult with private legal counsel.
- Refer to the Office of the Attorney General's website.
- Refer to Probate Code section 4701.

Step 2

Once the advance health care directive has been prepared and executed, information regarding the advance health care directive may be registered with the Secretary of State by completing the Registration of Written Advance Health Care Directive (pdf ~140KB; included). The Registration of Written Advance Health Care Directive is a voluntary filing. Once the Registration of Written Advance Health Care Directive form has been completed, the form should be mailed to:

Secretary of State
Advance Health Care Directive Registry
P.O. Box 942877
Sacramento, CA 94277-0001

- There is a $10 fee for filing a new registration form or a revocation of prior directive combined with a new registration.
- The same form can be used to amend information on a previously filed registration form or revoke the registration by checking the applicable box on the form. There is no fee for filing an amendment or revocation.
- The advance health care directive can be made a part of the Secretary of State registry by attaching a copy of the advance health care directive to the Registration of Written Advance Health Care Directive filed with the Secretary of State. As an alternative to providing a copy of the advance health care directive, its location can be indicated on the registration form.
- A registrant must re-register upon execution of a subsequent advance directive.

For further information, please refer to Probate Code sections 4701 and 4800 and to the Office of the Attorney General's website.
Registration of
Written Advance Health Care Directive
(Probate Code sections 4800-4805)

Important - Read all instructions before completing this form.

1. Check the applicable box (Note: Check only one box)

- New Registration
  - For a new registration, check this box and complete the entire form. **There is a $10.00 fee for registration of a new directive.**

- Amendment
  - For an amendment to a previously filed registration form (not the directive), check this box, complete Items 3 and 7 and the appropriate section that changed. There is no filing fee.

- Revocation Only
  - For a revocation (change) of a written advance health care directive that has been registered previously with the Secretary of State or a revocation of your registration, check this box and complete Items 3 and 7. There is no filing fee.

- Revocation (change) of Prior Directive and New Registration
  - For a revocation (change) of a written advance health care directive that has been registered previously and the registration of a new directive, check this box and complete the entire form. **There is a $10.00 fee for registering the new directive.**

2. Check the applicable statement(s):

- The written advance health care directive is attached.
- This serves as notification of intended place of deposit or safekeeping of a written advance health care directive.

3. Registrant's information:

<table>
<thead>
<tr>
<th>Name (Last)</th>
<th>(First)</th>
<th>(Middle)</th>
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</thead>
<tbody>
<tr>
<td>Street Address</td>
<td>City and State</td>
<td>Zip Code</td>
</tr>
<tr>
<td>Date of Birth</td>
<td>Place of Birth</td>
<td></td>
</tr>
</tbody>
</table>

Enter at least one item:

- a. Social Security Number
- b. Driver's License Number and State or Country Issuing
- c. Other Identifying Number Established By Law and State or Country Issuing

4. Agent information (if any):

<table>
<thead>
<tr>
<th>Name (Last)</th>
<th>(First)</th>
<th>(Middle)</th>
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<tbody>
<tr>
<td>Home Telephone Number</td>
<td>Work Telephone Number</td>
<td>Mobile Phone Number</td>
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</table>

5. Alternate agent information (if any):

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<th>Name (Last)</th>
<th>(First)</th>
<th>(Middle)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Telephone Number</td>
<td>Work Telephone Number</td>
<td>Mobile Phone Number</td>
</tr>
</tbody>
</table>

6. Intended place of deposit or safekeeping of the written advance health care directive (if applicable):

7. Signature of Registrant

Typed or Printed Name of Registrant
INSTRUCTIONS

Registering a written advance health care directive (directive) or its location is voluntary. Registration or failure to register does not affect the validity of the directive.

A directive or information regarding the location of a directive may be filed with the Secretary of State pursuant to Probate Code sections 4800-4805 by using this form. If any information on the registration form changes, or if the actual directive is revoked (changed), the registrant complete and submit this form to the Secretary of State.

A registrant must re-register upon execution of a subsequent directive.

1. If this is a new registration of your directive, check the New Registration box on the form and complete the entire form. Attach to the form a check payable to the Secretary of State in the amount of $10.00 and mail the check and completed form to the address below.

   If this is an amendment or change to a registration form that you have previously filed with the Secretary of State (for example, a change of address or a change in the location of your directive), check the Amendment box on the form, complete Items 3 and 7, and provide the information that changed in the applicable section. There is no filing fee. Mail the completed form to the address below.

   If this is notification that your directive previously registered with the Secretary of State has been revoked or has changed, and you are not registering a new directive with the Secretary of State, OR if you want to revoke your prior registration of your directive with the Secretary of State, check the Revocation Only box on the form and complete Items 3 and 7. There is no filing fee. Mail the completed form to the address below.

   If this is notification that your directive previously registered with the Secretary of State has been revoked or has changed, and you want to register a new Directive with the Secretary of State, check the Revocation (change) of Prior Directive and New Registration box on the form and complete the entire form. Attach to the form a check payable to the Secretary of State in the amount of $10.00 for the new registration and mail the check and completed form to the address below.

2. Check the appropriate statement indicating if your directive is attached to this form or if you are providing the location of the directive.

3. Print your name, address, date of birth and place of birth. Also include at least one of the following: social security number, driver's license number and state or country of issuance, or another form of identification issued by a government agency. The identification numbers will not be disclosed to the public; however, they will be used by this office to ensure the correct information for the correct person is provided to your health care provider when requested.

4. Print the full name and telephone number of your agent, if any, who is authorized to make health care decisions for you as indicated in your directive.

5. Print the full name and telephone number of your alternate agent, if any, who is authorized to make health care decisions for you as indicated in your directive.

6. Provide the address or location of the directive (e.g. safe in the closet in the spare room at 123 Any Street, Any City, CA 99999) if this is the purpose of the registration.

7. Sign, date and type or print your name below.

If you are unable to fill out or sign the form, another adult can complete it in your presence and at your direction. (2 Cal. Code of Regs. Section 22610.2(a))

Mail the completed form and any applicable filing fees to:

Secretary of State, Special Filings Unit, P.O. Box 942870 Sacramento, CA 94277-2870 (916) 653-3984

Note: Should you wish to register your organ and tissue donation choices, please do so with Donate Life, California's official Organ and Tissue Donor Registry, at https://register.donatelifecalifornia.org/register/.

Pursuant to Probate Code section 4800 and 2 Cal. Code of Regs. section 22610.2, the information on this form is requested by the Secretary of State’s Office, Special Filings Unit, P.O. Box 942870, Sacramento, CA 94277-2870, Telephone number (916) 653-3984. Providing the information is necessary in order to identify you should there be a request to receive information as specifically authorized by law. Information received on lines 3(a), 3(b), and 3(c) of the form will not be disclosed except as specifically authorized by law, although at least one of the items must be provided by you for identification purposes.

SFL-461 (Rev 04/2015)
## CONFIDENTIAL MORBIDITY REPORT

**PLEAS NOTE:** Use this form for reporting lapses of consciousness or control, Alzheimer’s disease or other conditions which may impair the ability to operate a motor vehicle safely (pursuant to H&S 103900).

### CONDITION BEING REPORTED

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<thead>
<tr>
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<th>First Name</th>
<th>MI</th>
<th>Ethnicity (check one)</th>
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<td>Hispanic/Latino</td>
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<td>American Indian/Alaska Native</td>
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<td>Asian (check all that apply)</td>
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<th>Country of Birth</th>
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<td>School</td>
<td>Day Care</td>
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<td>Other (specify):</td>
<td>Health Care</td>
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<th>Date of Diagnosis (mm/dd/yyyy)</th>
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<th>State</th>
<th>ZIP Code</th>
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<th>Date Submitted (mm/dd/yyyy)</th>
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(Obtain additional forms from your local health department.)

### DEPARTMENT OF MOTOR VEHICLES (DMV)

**California Driver License or Identification Card Number (eight characters):**

1. If this report is based upon episodic lapses of consciousness, when was the most recent episode? (mm/dd/yyyy)

2. If there have been multiple episodes of loss of consciousness or control within the past three years, please indicate the dates if they are known to you.

   (a): (mm/dd/yyyy)  (b): (mm/dd/yyyy)  (c): (mm/dd/yyyy)  (d): (mm/dd/yyyy)  (e): (mm/dd/yyyy)  (f): (mm/dd/yyyy)

3. Within the past 12 months, has there been an episode of loss of consciousness or control while driving?  Yes  No  Uncertain

4. Are additional lapses of consciousness likely to occur?  Yes  No  Uncertain

5. If the patient has had episodes of nocturnal seizures, is there likelihood of lapses of consciousness occurring while he/she is awake?  Yes  No  Uncertain

6. Has this patient been diagnosed with dementia or Alzheimer’s disease?  Yes  No  Uncertain

7. Would you currently advise this patient not to drive because of his/her medical condition?  Yes  No  Uncertain

8. Does this patient’s condition represent a permanent driving disability?  Yes  No  Uncertain

9. Would you recommend a driving evaluation by DMV?  Yes  No  Uncertain

### Remarks:

CDPH 110c (10/11) (for reporting conditions reportable to DMV)
### Section 8.4

**Title 17, California Code of Regulations (CCR) §2500, §2593, §2641.5-2643.20, and §2800-2812 Reportable Diseases and Conditions**

**§ 2500. REPORTING TO THE LOCAL HEALTH AUTHORITY.**

- **§ 2500(b)**: It shall be the duty of every health care provider, knowing of or in attendance on a case or suspected case of any of the diseases or conditions listed below, to report to the local health officer for the jurisdiction where the patient resides. Where no health care provider is in attendance, any individual having knowledge of a person who is suspected to be suffering from one of the diseases or conditions listed below may make such a report to the local health officer for the jurisdiction where the patient resides.

- **§ 2500(c)**: The administrator of each health facility, clinic, or other setting where more than one health care provider may know of a case, a suspected case or an outbreak of disease within the facility shall establish and be responsible for administrative procedures to assure that reports are made to the local officer.

**URGENCY REPORTING REQUIREMENTS (17 CCR §2500(i)(i))**

- Report immediately by telephone (designated by a * in regulations).
- Report immediately by telephone when two or more cases or suspected cases of foodborne disease from separate households are suspected to have the same source of illness (designated by a ** in regulations).
- Report by electronic transmission (including FAX), telephone, or mail within one working day of identification (designated by a * in regulations).
- *All other disease/conditions should be reported by electronic transmission (including FAX), telephone, or mail within seven calendar days of identification.*

### REPORTABLE COMMUNICABLE DISEASES §2500(i)(1)

- **Acquired Immune Deficiency Syndrome (AIDS)**
- **Malaria**
- **Smallpox (Variola)**
- **Sporadic Influenza, Invasive Disease (report an incident of less than 15 years of age)**
- **Hantavirus Infections**
- **Hemolytic Uremic Syndrome**
- **Hepatitis A, acute infection**
- **Hepatitis B (specify acute case or chronic)**
- **Hepatitis C (specify acute case or chronic)**
- **Hepatitis D (specify acute case or chronic)**
- **Hepatitis E, acute infection**
- **Influenza, deaths in laboratory-confirmed cases for age 6-64 years**
- **Influenza, novel strains (human)**
- **Legionellosis**
- **Listeriosis**
- **Malaria**
- **Measles (Rubella)**
- **Menigitis (specify etiology): Viral, Bacterial, Fungal, Parasitic**
- **Meningococcal Infections**
- **Mumps**
- **Paralytic Shellfish Poisoning**
- **Pelvic Inflammatory Disease (PID)**
- **Pertussis (Whooping Cough)**
- **Plague, human or animal**
- **Poliovirus Infection**
- **Poliomyelitis**

**HIV REPORTING BY HEALTH CARE PROVIDERS §2641.5-2643.20**

- Human Immunodeficiency Virus (HIV) infection is reportable by traceable mail or person-to-person transfer within seven calendar days by completion of the HIV/AIDS Case Report form (CDPH 6841A) available from the local health department. For completing HIV-specific reporting requirements, see Title 17, CCR, §2641.5-2643.20 and http://www.cdph.ca.gov/programs/lds/Pages/OAH/Reporting.aspx

### REPORTABLE NONCOMMUNICABLE DISEASES AND CONDITIONS §2500-2512 and §2593(b)

- **Disorders characterized by Lapses of Consciousness (§2500-2512)**
- **Carcinoma in situ and CIN III of the Cervix (§2593)**

**LOCALLY REPORTABLE DISEASES (if Applicable):**

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*This form is designed for health care providers to report those diseases mandated by Title 17, California Code of Regulations (CCR). Failure to report is a misdemeanor (Health & Safety Code §120295) and is a cite offense under the Medical Board of California and Fire Program (Title 16, CCR §1356 10 and 1356 11). Failure to report is a cite offense and subject to civil penalty (§2500) (Health and Safety Code §105200). The Confidential Physician Cancer Reporting Form may also be used. See Physician Reporting Requirements for Cancer Reporting in California at www.ccr.ca.org.

CDPH 110C (10/11)
Prepare for Your Care (PREPARE) is a FREE online resource that helps people understand and make decisions about their medical care.

Using video stories, PREPARE helps people explore their wishes and learn how to discuss them with family, friends, and medical providers.

www.prepareforyourcare.org

**FREE ACCESS and FREE TOOLS**

PREPARE offers free support tools to help physicians and patients, in Spanish and English.

- The PREPARE pamphlet is an easy way to introduce patients to PREPARE and start the conversation.
- An Easy-to-Read Advance Directive for California is available in 10 languages.**
- A movie version of the videos can be shared in any group setting.
- A Tool Kit with printable materials supports a group viewing of the PREPARE movie.

* Sudore RL, Boscardin J, Feuz MA, McMahan RD, Katen MT, Barnes DE. Effect of the PREPARE Website vs an Easy-to-Read Advance Directive on Advance Care Planning Documentation and Engagement Among Veterans; a Randomized Clinical Trial. JAMA Intern Med. 2017 Aug 1;177(8):1102-1109.

** English, Armenian, Chinese, Farsi, Khmer, Korean, Russian, Spanish, Tagalog, and Vietnamese.
THINGS MY LOVED ONES NEED TO KNOW ABOUT ME

Provided as a public service for older adults, persons with disabilities, and their caregivers by:

Office on Aging
Information and Assistance
1-800-510-2020
www.officeonaging.ocgov.com

Completed/updated on this date, _____________ _______________ ______________
(Most recent date applies)

By ________________________________________________________________
(Print complete name clearly)

My Legal Residence:

________________________________________________________ Apt. # _____

City_____________________________________ Zip___________________

Phone (____)__________________Alternate/Cell (____)_____________________

Person (nearby) who knows where to find and has access to my important papers

My important papers are located here:

Safe Deposit Box #___________________

Bank/branch:

Key is located here:

Authorized signer
PERSONAL DATA

(These are required for insurance purposes, social security, pensions, and in other cases where legal proof of age, relationships, or birthplace is required.)

☐ Birth date: ______________ City __________
County ______________ State __________
My birth certificate is located here:

Country (If not USA)

Date entered the USA: _________________
Citizenship papers are located here:

MARRIAGE
(If married more than once, use additional page.)

I am currently married. ___ Yes ___ No
Spouse: _______________________________
Date: From ______________ To ______________
Place __________________________________
Marriage Records located at

If Widowed:
The deceased’s name: _______________________
Date of death: ______ Cause: __________________

If divorced or separated:
_____ I was divorced   ___ I was legally separated
Name of partner: _________________________
Year of marriage ______ of dissolution ______
City: ______________ State _____

PARENTS

Father: _________________________________
Date of birth ______ Date of death ______
Burial Site _____________________________
Mother: _______________________________
Date of birth ______ Date of death ______
Burial site: ____________________________

CHILDREN
List name, (maiden name), and birthdates:

__________________________
__________________________
__________________________

MILITARY SERVICE (Complete if applicable)

Branch of service: ___________________________
Discharge date: _____________ Type ___________
Highest Rank/Grade__________________________
Military Serial Number_________________________
Military discharge and pension papers are located:

If disabled veteran:  Claim number ______________
Service connected disabilities and %:
Describe where or how injuries occurred.
FINANCIAL MATTERS

PRESENT EMPLOYMENT
My present employer is: ______________________
Address ___________________________________
Phone: ___________________ FAX ________________
Date started: ________ Supervisor: ______________
Social Security card is located: _________________

PAST EMPLOYMENT
I am eligible for the following pension, profit-sharing, or benefit plans: (Include necessary information).
___________________________________________
___________________________________________
___________________________________________
I am ___ was ___ never was ___ Member of a union
Union name and how to contact:
___________________________________________
___________________________________________

SELF-EMPLOYMENT
If you own or owned a business of your own, fill in the blanks below:
Name of business ____________________________
Address: ___________________________________
___________________________________________
Contact persons/Phones
___________________________________________

CHECKING AND SAVINGS ACCOUNTS
Name(s) on checking account:
___________________________________________
Bank: _______________________________________
Person who knows account number:
___________________________________________
Name(s) on savings account:
___________________________________________
Bank: _______________________________________
Person who knows account number:
___________________________________________
Name(s) of anyone else who has power to sign checks
ATM card or passbook location:
___________________________________________
Person who knows password/ID
___________________________________________

REAL ESTATE (if more than one, attach information)
I do ___ do not ___ own real estate
Co-owner (if applicable):
___________________________________________
Address (if not the same as your residence)
___________________________________________
My mortgage is held by:
___________________________________________
Taxes are paid on this property until: _____________
The deed, tax, and mortgage documents are located:
___________________________________________
STOCKS and BONDS and ANNUITIES
I do ___ do not ___ own stocks and/or bonds

An updated list of all my stocks and bonds and their numbers and beneficiaries can be found here:

Certificates are located here: ____________________________

I do ___ do not ___ have a brokerage account.
If so, my broker can be contacted here:
Name: _____________________________________
Firm:   _____________________________________
Phone: (____) _____________________________

I have these securities pledged for loans:

Information on these can be found here:

CAR(S) make, model, year:

Location of pink slip(s)
_________________________

JOINT OWNERSHIP
I do ___ do not ___ own any property jointly
If so, partner information can be found here:

LIFE INSURANCE
I do___ do not ___ have life insurance on:

Complete itemized list and policies can be found:

My principal insurance broker is:
Name (Company)
_________________________________________

Phone (_____) _____________________________

I do ___ do not ___ have annuities
Location of annuity contracts: ____________________________

MEDICAL and LONG TERM INSURANCE
I am covered ___ not covered ___ by Medicare
Part A ___ Part B ___ Part D ___ Medi-Medi ___
I am in this HMO/Plan ________________________
Plan contact phone: __________________________

My primary physician:
Phone (_____)_______________________________

Additional medical, long-term care, supplemental or corporate insurance policy issuers:

Location of insurance policies: _______________

My designated caregiver: ____________________
Can be reached at: __________________________

TRUST FUNDS
I have created a trust fund to care for: _____________

Lawyer who drew up trust:

Trust agreement is located:

PERSONAL PROPERTY
All of my personal property, including real estate, furnishing, vehicles, and heirlooms are itemized and assigned in my will. Yes ___ No ___
MISCELLANEOUS ASSETS
I have ___ have not ___ these additional assets:
___ Fraternal and benevolent memberships
___ Royalty rights or patents
___ Debts due me
___ Others ______________________________

You can find documents pertaining to these here:
_______________________________________

CREDIT CARDS
I possess the following credit cards:
_______________________________________
_______________________________________
_______________________________________

TAX RECORDS and RETURNS
Copies of this year’s and previous years’ tax returns are and supporting documents are located here:
________________________________________
_________________________________________

BURIAL (You need to complete if not in your will)
I wish ___ do not wish ___ to be buried.
I do ___ do not ___ own a burial plot.
Cemetery name ____________________________
Location of deed: ___________________________
There is __ is not __ provision for perpetual care

I prefer to be buried here: (No contract signed)
__________________________________________

I wish for cremation or other disposition of my body.
Specify: __________________________________
__________________________________________

RELIGIOUS AFFILIATION
Church or temple: _________________________
Address _________________________________
________________________________________

Clergy member: _________________________
Phone: (_____) __________________________

MY WILL or LIVING TRUST
My will (or trust) is the document that assures that, when I die, my property is distributed as I wish – otherwise the state will do so according to state laws. Please be sure my last will (and any revisions) are honored.

Original executed copy of my will (and any codicil (revision) or Living Trust is located:
_______________________________________

The attorney who drew it up is:
Name: _________________________________
City: _________________________________
Phone: (______) __________________________

Name of Executor: ______________________
Where to reach executor:
_____________________________________

Witness to Will:
1. ___________________________________

Reachable at: _________________________

I have a Durable Power of Attorney (Financial)
___ Yes ___ No
If so, it is located here:
_____________________________________

Attorney who drew this document up:
_____________________________________

Phone: (_____) __________________________

I have an Advance Health Care Directive
(States your health support options or appoints person to speak for you) ___ Yes ___ No
If so, copies are located here:
_____________________________________

AWV Toolkit
People (and phone numbers) to contact if I should become seriously ill:

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

People I don’t wish to be contacted:

_________________________________________

_________________________________________

Things that I wish to do or have done for me:

_________________________________________

_________________________________________

The Information and Assistance line, 1-800-510-2020, can give you information for older adults and persons with disabilities on transportation, in-home care, housing, food, caregiving, abuse, day care, health, health insurance, legal assistance and more.
TIPS FROM GERIATRICIANS

1. If cognitive impairment is diagnosed, assess if the patient can comprehend, evaluate and choose among care options before assuming such capacity is absent.

2. Be alert to depression and burn-out in your patients’ caregivers.

3. Remain aware for potential financial, mental and physical abuse and self-neglect in frail elders.

4. Use your “Sherlock” skills during your initial moments with a patient:
   a. Is the patient’s manner of dress consistent with previous visits?
   b. Is there an odor of urine or fecal incontinence?
   c. Are the clothes clean and appropriately fitted?
   d. Are there any visible skin changes?
   e. Do you need to speak more loudly for the patient to hear you? (If yes, consider using a pocket talker to assist communication.)
   f. Do the shoes appear appropriate?

5. Write down all instructions and medication changes for the patient and/or caregivers. Use large and bold font for all written communications, including appointment reminders.

6. Review all medications and let the patient and/or caregiver know the ones that should not be crushed. Many elders will crush oral medications before swallowing.

7. Remind elders of risks of using over-the-counter diphenhydramine (available in sleep and cold preparations) that include delirium, urinary retention, and constipation.

8. Routinely include a social history to assess the patient’s daily life and functional status. Ask about sexual activity and high risk behaviors for sexually transmitted diseases and HIV.

9. California providers are required to report lapses of consciousness or control and conditions that potentially lead to unsafe driving which includes cognitive impairment. Available at: http://www.ochealthinfo.com/civicax/filebank/blobdload.aspx?BlobID=13139. Accessed 5/2/17

10. Physicians should engage with adult patients and their families in advance care planning to understand and document the patients’ end of life wishes and values. For patients with a diagnosed terminal illness or extremely frail condition, consider completion of a POLST (Physicians’ Orders for Life Sustaining Treatment) in addition to an Advanced Directive. (www.capols.org). By recording the patient’s healthcare preferences with tools such as Advance Directives or POLST, the patient is more likely to receive desired treatments and avoid treatments that the patient does not desire, even if the patient later loses decisional capacity.

11. The American Geriatrics Society has an excellent source for information on elder care, available at https://geriatricscareonline.org. The publication Geriatrics at Your Fingertips is a handy, pocket-sized reference that is updated annually.