填写您的生前预嘱和医疗授权书

Completing your living will and medical power of attorney

如果您无法代表您自己，则这些说明将有助于您作出医疗决策。中文副本应附在已填写完整并签署姓名的英文副本上，医务人员需要此副本才能完成您的愿望。

These instructions will help you make medical decisions if you cannot speak for yourself. The Chinese copy should be attached to a completed and signed English copy, which medical personnel require in order to carry out your wishes.

填写您的生前预嘱

Completing Your Living Will

请将您的姓名打印在首个空白行上。“我，我的姓名，希望每个护理我的人士在我无法代表我自己时知晓我的心愿。”

Print your name on the first blank line. "I, MY NAME, want everyone who cares for me to know what I want when I cannot speak for myself."

第 1 部分：什么样的生存质量是您无法接受的？您希望您的家人和医生何时停止或放弃治疗？选中表明您不希望在那种病情下继续生存的复选框。您可以在空白行上添加您自己的想法，也可以在表格中划去您不同意的任何内容。

Section 1: What kind of quality of life is unacceptable to you? When would you want your family and doctors to stop or withdraw treatment? Check boxes indicating that you do not want to live in that condition. You may add your own words on the blank line or cross out anything on the form you do not agree with.

第 2 部分：可能具有在任何情况下您都不希望行使的某些程序。如果您已经决定不再需要所列的一种疗法，请选中该框。如果您尚未决定或者希望您的医生尝试这些疗法，则请将该框留空。

Section 2: There may be some procedures you would not want under any circumstances. If you have decided you would never want one of the treatments listed, check that box. If you have not decided yet, or want your doctor to try these treatments, leave the box blank.

第 3 部分：请考虑以下声明：“在我生命垂危之时，重要的是……”您可以在此处写下任何心愿。有人表示，“我希望获得临终关怀。我希望在家中过世。我希望家人在我身边。我希望死后被火化。”如果您愿意的话，也可以将这些行留空。

Section 3: Think about the statement: "When I am near death, it is important that…" You may write anything you want here. Some say, "I want hospice care. I want to die at home. I want family near me. I want to be cremated when I die." You may leave these lines blank if you wish.

请在此表格的背面签名，并由与您没有血缘、婚姻或收养关系的人见证该签名。见证人不得为您遗产的受益人，也不得直接参与您的医疗保健。

Sign this form on the reverse side and have the signature witnessed by a person who is not related to you by blood, marriage or adoption. The witness cannot be a beneficiary to your estate or be directly involved in your healthcare.

无需在亚利桑那州对此表格进行公证，但是如果您愿意的话，可以为公证人留出空间。

It is not necessary to have this form notarized in Arizona, but there is a space for a notary if you wish.

将此表格和您的医疗授权书表格附在此表格已填写完整并签署姓名的英文版本上。请将副本交给您的家人、好友和医生。如果您生病且需要治疗，请带上副本前往医院就诊。

Attach this form and your Medical Power of Attorney form to a completed and signed English version of this form. Give copies to your family, close friends and doctor. Take copies to the hospital if you become ill and need treatment.

HOSPICE of the VALLEY

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填写您的医疗授权书

Completing Your Medical Power of Attorney

请将您的姓名打印在首个空白行中。“我，我的姓名，作为委托人，指定……”

Print your name in the first blank line. “I, MY NAME, as principal, designate…”

请将您选择作为您的医疗委托人的姓名打印在下一空白行上。“其他人的姓名，作为我的全权代理人……”

Print the name of the person you choose to be your Medical Power of Attorney on the next blank line. “OTHER PERSON’S NAME, as my agent for all matters…”

如果您的代理人有权根据您的医生的指示允许您接受住院或精神病治疗方案，则请以您姓名的首字母签名。

Initial if you give your agent the power to admit you to an inpatient or psychiatric program if ordered by your doctor.

如果您希望明确表明，即使您无行为能力，亦不得撤销本文件，则请以您姓名的首字母签名。

Initial if you want to make it clear that this document may not be revoked if you are incapacitated.

请将您所选医疗委托人的地址和电话号码打印在下一空白行上。地址和电话

Print the address and phone number of your chosen Medical Power of Attorney on the next blank line. ADDRESS AND PHONE

如果首选人员不在或无法代您作出决定，您可以选择候补医疗委托人。“作为我的代理人的第二人的姓名……”

You may choose an alternate Medical Power of Attorney in case the first person is not available or unable to make decisions for you. “SECOND PERSON”S NAME as my agent…”

打印该人士的地址和电话。如果您并未选择候补委托人，则将这些行留空。

Print that person’s ADDRESS and PHONE. If you do not choose an alternate, leave the lines blank.

请在与您无血缘、婚姻或收养关系的证人面前签署此表格。见证人不得为您遗产的受益人，也不得直接参与您的医疗保健。

Sign this form in front of a witness who is not related to you by blood, marriage or adoption. The witness cannot be a beneficiary to your estate or be directly involved in your healthcare.

无需在亚利桑那州对此表格进行公证，但是如果您愿意的话，可以为公证人留出空间。

It is not necessary to have this form notarized in Arizona, but there is space for a notary if you wish.

将此表格和您的生前预嘱表格附在此表格已填写完整并签署姓名的英文版本上。请将副本分给您的家人、好友和医生。如果您生病且需要治疗，请随身携带副本前往医院就诊。

Attach this form and your Living Will form to a completed and signed English version of this form. Give copies to your family, close friends and doctor. Take copies to the hospital if you become ill and need treatment.

医疗保健指示(生前预嘱)

Health Care Directive (Living Will)

我, _____, 希望每个护理我的人士在我无法告知他人我的心愿之时清楚我希望获得何种医疗保健。

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

第 1 部分 (SECTION 1):

我希望我的医生尝试采用使我恢复可接受的生存质量的疗法。然而,如果我的生存质量变得无法接受,并且我的病情不会改善(不可恢复),则会指示放弃延长我生命的所有疗法。

I want my doctor to try treatments that may get me back to an acceptable quality of life. However, if my quality of life becomes unacceptable to me and my condition will not improve (is irreversible), I direct that all treatments that extend my life be withdrawn.

我无法接受的生存质量意指(请选中所有适用项): A quality of life that is unacceptable to me means (check all that apply):

☐ 人事不省(慢性昏迷或持续性植物状态) Unconscious (chronic coma or persistent vegetative state)
☐ 无法表达我的需求 Unable to communicate my needs
☐ 无法认出家人或朋友 Unable to recognize family or friends
☐ 完全或几乎完全依赖他人护理 Total or near total dependence on others for care
☐ 其他 Other: _____

仅勾选一项 (Check only one):

☐ 即使我的生存质量如上所述,我仍希望通过喂食管或静脉内 (IV) 补给食物和饮水来进行治疗。 Even if I have the quality of life described above, I still wish to be treated with food and water by tube or intravenously (IV).

☐ 如果我的生存质量如上所述,我不希望通过喂食管或静脉内 (IV) 补给食物和饮水来进行治疗。 If I have the quality of life described above, I do NOT wish to be treated with food and water by tube or intravenously (IV).

第 2 部分 (SECTION 2): (您可以将此部分留空。) (You may leave this section blank.)

即使可能会康复,但有些人在任何情况下均不希望接受某些疗法。
Some people do not want certain treatments under any circumstance, even if they might recover.

请选中以下您在任何情况下均不希望接受的疗法:
Check the treatments below that you do not want under any circumstances:

☐ 心肺复苏术 (CPR) Cardiopulmonary Resuscitation (CPR)
☐ 换气(呼吸机) Ventilation (breathing machine)
☐ 喂食管 Feeding tube
☐ 透析) Dialysis
☐ 其他 Other: _____

第 3 部分 (SECTION 3):

在我生命垂危之时,对我来说重要的是 When I am near death, it is important to me that: _____

_____

(例如临终关怀、死亡地点、丧葬事务、火葬或土葬选择。)
(Such as hospice care, place of death, funeral arrangements, cremation or burial preferences.)

请务必在此表格的背面签名

BE SURE TO SIGN THE REVERSE SIDE OF THIS FORM

- 如果您仅想填写医疗保健(医疗)授权书,请在此页上打一个大 X。
  If you only want a Health Care (Medical) Power of Attorney, draw a large X through this page.
- 请与您选择的可以代您作出决定的人士、您的医生、您的家人和朋友一起讨论这份表格。请分给他们每人一份此表格的副本。
  Talk about this form with the person you have chosen to make decisions for you, your doctor(s), your family and friends. Give each of them a copy of this form.
- 每当您前往医院或在旅途中时,请随身携带一份此副本。 Take a copy of this with you whenever you go to the hospital or on a trip.
- 您应该经常回顾这份表格。 You should review this form often.
- 您可以随时废除或更改此表格。 You can cancel or change this form at any time.

有关更多信息,请通过以下方式与 Health Care Decisions 联络

(602) 222-2229 或 hov.org\healthcare-decisions

For more information contact Health Care Decisions, (602) 222-2229 or hov.org\healthcare-decisions

精神保健管理局的医疗保健(医疗)授权书

Health Care (Medical) Power of Attorney with Mental Health Authority

当您无法自行作出决定时,请务必选择可以代您作出医疗保健决策的某人士。告诉您选择的人士(代理人)您希望接受的疗法。为确保您如愿以偿,您选择的人士有权作出任何决定。如果您不希望选择他人代您作出决定,请在代理人姓名一行中写下无。

It is important to choose someone to make healthcare decisions for you when you cannot. Tell the person (agent) you choose what you would want. The person you choose has the right to make any decision to ensure that your wishes are honored. If you DO NOT choose someone to make decisions for you, write NONE in the line for the agent's name.

我, _____, 作为委托人,指定 _____
作为我的代理人处理与我的健康(包括精神健康)有关的所有事务,包括但不限于同意或拒绝同意所有医疗、外科、医院和相关医疗保健的全部权力。这份授权书在我无法作出或传达医疗保健决定时生效。在我无法作出或传达医疗保健决定或者不确定我是死亡还是活着的任何时候,我的代理人在此权力下采取的所有行动对我的继承人、受遗赠者和遗嘱代理人的影响均与我还活着、有能力并为自己行事的效果相同。

I, ___xxx___ , as principal, designate ___xxx___ as my agent for all matters relating to my health (including mental health) and including, without limitation, full power to give or refuse consent to all medical, surgical, hospital and related health care. This power of attorney is effective on my inability to make or communicate health care decisions. All of my agent's actions under this power during any period when I am unable to make or communicate health care decisions or when there is uncertainty whether I am dead or alive have the same effect on my heirs, devisees and personal representatives as if I were alive, competent and acting for myself.

_____ 通过在此处以我姓名的首字母签名,我特别同意我的代理人有权根据医生的指示允许我接受住院或部分精神病住院治疗方案

By initialing here, I specifically consent to giving my agent the power to admit me to an inpatient or partial psychiatric hospitalization program if ordered by my physician.

_____ 通过在此处以我姓名的首字母签名,即使我无行为能力,亦不得撤销包括精神健康护理授权书在内的本医疗保健指示。

By initialing here, this Health Care Directive including Mental Health Care Power of Attorney may not be revoked if I am incapacitated.

打印代理人的地址和电话 (Print agent ADDRESS and PHONE):

_____

如果我的代理人不愿或无力提供服务或继续提供服务,我特此委托 (If my agent is unwilling or unable to serve or continue to serve, I hereby appoint):

_____ 作为我的代理人。打印候补代理人的地址和电话

(Print alternate agent ADDRESS and PHONE):

_____

在使用和披露可识别的个人健康信息或其他病历方面,我希望我的经纪人享有与我相同的待遇。此豁免授权适用于受 1996 年《健康保险可携性及责任性法案》(又名 HIPAA)、42 USC 1420D 和 45 CFR 160-164 约束的任何信息。

I intend for my agent to be treated as I would regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (aka HIPAA), 42 USC 1420D and 45 CFR 160-164.

健(医疗)授权书和/或医疗保健指令表格

SIGN HERE for the Health Care (Medical) Power of Attorney and/or the Health Care Directive forms

请让一位与您无关或与您或者您的遗产有财务关系的人士见证您的签名。 Please ask one person to witness your signature who is not related to you or financially connected to you or your estate.

签署 (Signature): _____ 日期 (Date): _____

上面提及的此人经本人确认无误,我相信他/她心智健全并自愿填写此文件。我至少年满 18 岁,与他/她之间无血缘、婚姻或收养关系,也并非本文件中指定的代理人。据我理解,我并非他/她的遗嘱或任何遗嘱修改附录的受益人,因此我无权继承他/她的遗产。我并未直接参与他/她的医疗保健。

The above named person is personally known to me, and I believe him/her to be of sound mind and to have completed this document voluntarily. I am at least 18 years old, not related to him/her by blood, marriage or adoption, and not an agent named in this document. I am not to my knowledge a beneficiary of his/her will or any codicil, and I have no claim against his/her estate. I am not directly involved in his/her health care.

见证人 (Witness): _____ 日期 (Date): _____

可以公证而非见证本文件。 (This document may be notarized instead of witnessed.)

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 THEREOF, I have set my hand and affixed my official seal in the County of _____ , State of _____, on the date written above.

Notary Public (公证人): _____