AzHHA
Arizona Hospital and Healthcare Association

ARIZONA MEDICAL LIVING WILL

亚利桑那州医疗生前预嘱

This Medical Living Will is effective only while I am unable to make or communicate my healthcare decisions. If I'm so sick I could die soon, I want everyone who cares for me to know what healthcare I want when I am not able to tell them myself. Please initial your preferences below.

这份医疗生前预嘱仅在我无法沟通或做出医疗决策时生效。如果我病重到可能很快会死亡，我希望所有照护我的人都知道在我无法亲自告诉他们我的决定时希望接受什么样的医疗干预。请在下方签署姓名首字母缩写标记您的选择。

1. _____ I want ALL life support treatments that my medical providers think might help. (*If you initial here, do not initial sections 2 or 3.)*

1. _____ 我希望接受所有我的主治医生认为可能对我**生命维持**有帮助的**治疗方案。** *(如果您在此处签署姓名首字母缩写，请勿在第2或第3部分签名。)*

OR
或者

2. _____ I want my medical providers to try life support treatments that they think might help, except I **do not want** the following treatments (check the boxes below):

2. _____ 我希望我的主治医生尝试他们认为可能对我生命维持有帮助的**治疗方案**，但我**不希望**接受以下治疗（在下面方框中打勾）：

CPR 心肺复苏	☐ No/否	Dialysis 透析	☐ No/否
Breathing Machine 呼吸机	☐ No/否	Antibiotics 抗生素	☐ No/否
Feeding Tubes 食管插管（胃管）	☐ No/否	Blood Transfusions 输血	☐ No/否
IV Fluids 静脉补水	☐ No/否		

OR
或者

3. _____ I DO NOT want life support treatments. I want to focus on being comfortable. I want to have a natural death.

3. _____ 我不希望接受生命维持治疗方案。我希望专注于舒适。我希望自然死亡。

Attached are additional directions to this Living Will: (Please check) ☐ DNR or Prehospital Medical Care Directive ☐ POLST
附加到本生前预嘱的其他说明：（请勾选）☐ 拒绝心肺复苏术或院前医疗照护指示 ☐ 维持生命医嘱

☐ Additional Statements/Desires 其他声明/愿望：_____

_____

Organ Donation:
器官捐献：

Do you want to be an organ, eye and/or tissue donor? (Initial Yes or No) Yes _____ No _____
您想成为器官、眼睛和/或组织捐赠者吗？（在"是"或"否"处签署姓名首字母缩写）是 _____ 否 _____

If yes, circle what you want donated: any organ eye tissue or Specify: _____
如果是，请圈出您想捐赠的器官：任何器官 眼睛 组织 或 指定器官：_____

Signature: This is a legal document. By signing it, you acknowledge that you have reviewed it carefully and it reflects your wishes. For this form to be used, you must be at least 18 years old and have a witness or notary watch you sign this form.

签名：这是一份法律文件。通过签署它，您承认您已仔细审阅，并且它反映了您的愿望。您必须年满18岁才能使用此表格，

Revised 10/20
修订日期：2020年10月

并且有见证人或公证人见证您签署此表格。

Sign Your Name 签名 | Today's Date 今天的日期 | Date of Birth 出生日期

Print Your First Name 正楷名字 | Print Your Last Name 正楷姓氏 | Address 地址

Witness
见证人

I was present when this Medical Living Will was signed and dated. The person seemed to be thinking clearly and was not forced to sign this Medical Living Will. I also promise that I am: 1) at least 18 years of age; 2) not the person's medical decision maker; 3) not part of the person's healthcare team; 4) not related by blood, marriage, or adoption; and 5) not going to get any part of the person's estate (such as money or property) after he/she dies.

我在此医疗生前预嘱书签署时在场。此人在签署此医疗生前预嘱时似乎头脑清晰且没有被强迫签署。我还承诺我：1) 已年满18岁；2) 不是签署人的医疗决策者；3) 不是签署人的医疗团队成员；4) 与签署人没有血缘、婚姻或收养关系；以及 5) 在签署人去世后不会获得其遗产（如金钱或财产）的任何一部分。

Witness Signature 见证人签名 | Date 日期

Witness Print First Name Witness 见证人正楷名字 | Print Last Name 见证人正楷姓氏 | Address 地址

This document may be notarized instead of witnessed (optional).
也可以选择公正而非见证此文件（可选）

State of Arizona)
亚利桑那州)
County of _____)
_____县)

On this ____day of _____, 20____, before me personally appeared _____whose identity was proven and he or she appeared to be of sound mind and free from duress, fraud or undue influence and he or she signed the above document.

在 20____年_____月_____日，我亲自见证了_____的签名，其身份得到证明，他/她似乎精神正常，没有受到胁迫、欺诈或不当影响，并且他/她签署了上述文件。

NOTARY PUBLIC 公证人

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We encourage you to also complete your Healthcare Power of Attorney. Talk about this form and your wishes about your healthcare with your Healthcare Power of Attorney, your medical provider(s), and your loved ones. Give each of them a copy of this form. You should review this form often and update as needed. You may cancel this form at any time.

我们鼓励您也完成您的医疗保健授权书。与您的医疗保健授权书持有人、您的医疗提供者以及您所爱的人讨论此表格和您对医疗照护的愿望。请给他们每人一份此表格的副本。您应该经常审阅此表格并根据需要进行更新。您也可以随时取消此表格。

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ARIZONA HEALTHCARE POWER OF ATTORNEY WITH OPTIONAL MENTAL HEALTH AUTHORITY

亚利桑那州医疗保健授权书（包括可选的精神健康权利）

This form lets you choose a medical decision maker (healthcare power of attorney) if you cannot communicate or make those decisions yourself. A medical decision maker must be at least 18 years of age and should be someone who knows your wishes and values and who you trust to carry out your wishes. It may be a family member or friend.

此表格让您在无法沟通或做出这些决定时选择一个医疗决策者（医疗保健授权书持有人）。医疗决策者必须年满18岁，应该了解您的愿望和价值观，并且是您信任能够执行您愿望的人，可以是您家庭成员或朋友。

By signing this form, you give your medical decision maker full power to make healthcare decisions for you, including to: 1) Choose your medical providers, caregivers, treatment options and where you receive care; 2) Agree to, refuse or withdraw life support or medical treatment. You may also choose to give your medical decision maker the power to make mental health decisions for you; and 3) Decide what happens to your body after you die, such as funeral arrangements and organ donation, if you have not made other arrangements.

通过签署此表格，您授予您的医疗决策者全面的医疗保健决策权，包括：1) 选择您的医疗提供者、照护人员、治疗方案和您接受照护的地方；2) 同意、拒绝或撤回生命维持或医疗治疗。您也可以选择授予您的医疗决策者做出有关精神健康医疗照护决策的权利；以及 3) 决定您去世后的遗体处理方式，如葬礼安排和器官捐献（如果您没有做出其他安排）。

MEDICAL DECISION MAKER - I want this person to make my medical decisions if I am not able to make my own:
医疗决策者 - 如果我不能自己做出决定，我希望此人做我的医疗决策者：

First Name 名字 _____ Last Name 姓氏 _____ Relationship 关系 _____ Phone 电话号码 _____

Address 地址 _____ Email Address 电子邮箱地址 _____

If the first person cannot do it, then I want this person to make my medical decisions:
如果第一个人不能胜任，我希望此人做我的医疗决策者：

First Name 名字 _____ Last Name 姓氏 _____ Relationship 关系 _____ Phone 电话号码 _____

Address 地址 _____ Email Address 电子邮箱地址 _____

MENTAL HEALTHCARE POWER OF ATTORNEY - This section must be initialed in front of a witness or a notary.
精神医疗保健授权书 - 此部分必须在见证人或公证人面前签名。

____ Initial here, to allow your medical decision maker the power to make mental healthcare decisions for you.
在此签署姓名首字母缩写，允许您的医疗决策者有权替您做出精神保健医疗照护决策。

____ Initial here, to allow your medical decision maker the power to admit you to an inpatient or partial psychiatric hospitalization program.
在此签署姓名首字母缩写，允许您的医疗决策者有权将决定您接受住院或部分精神病住院治疗方案。

If there are mental health decisions you do not want them to make, write them here: _____
如果您不希望他们做出某些精神健康医疗决定，请在此写明：_____

This section may not be revoked if you are not able to make decisions for yourself, as determined by your physician.
如果您的医生确定您无法自主做出决定，则此部分不能撤销。

This is a legal document. By signing it, you acknowledge that you carefully reviewed it and that the information reflects your wishes regarding who can make medical decisions for you, what those decisions should be, and that those wishes should be honored. ***In order for this form to be valid, you must be at least 18 years old and have one witness or a notary watch you sign this form.***

这是一份法律文件。通过签署它，您承认您已仔细审阅，并且这些内容反映了您的愿望，即谁能做您的医疗决策者、这些决策应该是什么，并且这些愿望应得到尊重。***为了使此表格有效，您必须年满 18 岁，并且有见证人或公证人见证您签署此表***

格。

Sign Your Name 签名	Today's Date 今天的日期	Date of Birth 出生日期

Print Your First Name 正楷名字	Print Your Last Name 正楷姓氏	Address 地址

Witness
见证人

I was present when this Medical Power of Attorney was signed and dated. The person seemed to be thinking clearly and was not forced to sign this Medical Power of Attorney. I also promise that I am: 1) at least 18 years of age; 2) not the person's medical decision maker; 3) not part of the person's healthcare team; 4) not related by blood, marriage, or adoption; and 5) not going to get any part of the person's estate (such as money or property) after he/she dies.

我在此医疗保健授权书签署时在场。此人在签署此医疗保健授权书时似乎头脑清晰且没有被强迫签署。我还承诺我：1) 已年满18岁；2) 不是签署人的医疗决策者；3) 不是签署人的医疗团队成员；4) 与签署人没有血缘、婚姻或收养关系；以及 5) 在签署人去世后不会获得其遗产（如金钱或财产）的任何一部分。

Witness Signature 见证人签名	Date 日期

Witness Print First Name 见证人正楷名字	Witness Print Last Name 见证人正楷姓氏	Address 地址

This document may be notarized instead of witnessed (optional).
也可以选择公正而非见证此文件（可选）

State of Arizona)
亚利桑那州)
County of _____)
_____县)

On this ____day of _____, 20___, before me personally appeared _____whose identity was proven and he or she appeared to be of sound mind and free from duress, fraud or undue influence and he or she signed the above document.

在20____年_____月_____日，我亲自见证了_____的签名，其身份得到证明，他/她似乎精神正常，没有受到胁迫、欺诈或不当影响，并且他/她签署了上述文件。

_____
NOTARY PUBLIC 公证人

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