AzHHA
Arizona Hospital and Healthcare Association

ARIZONA MEDICAL LIVING WILL

亞利桑那州醫療生前預囑

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.

這份醫療生前預囑僅在我無法溝通或做出醫療決策時生效。如果我病重到可能很快就會死亡，我希望所有照顧我的人都知道在我無法親自告訴他們我的決定時希望接受什麼樣的醫療幹預。請在下方簽署姓名首字母縮寫標記您的選擇。

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**我的主治醫生認為可能對我**生命維持**有幫助的**治療方案。** *(如果您在此簽署姓名首字母縮寫，請勿在第2或第3部分簽名。)*

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. _____ **我希望我的主治醫生嘗試**他們認為可能對我生命維持有幫助的**治療方案**，但我**不希望**接受以下治療（在下面方框中打勾）：

CPR 心肺復甦	☐ 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 輸血	☐ No/否
IV Fluids 靜脈輸液	☐ 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. _____ **我不希望接受生命維持治療方案。**我希望專注於舒適。我希望自然死亡。

Attached are additional directions to this Living Will: (Please check) ☐ DNR or Prehospital Medical Care Directive ☐ POLST
附加到本生前預囑的其他說明：（請勾選）☐ 拒絕心肺復甦或院前醫療照顧指示 ☐ 生命維持醫囑

☐ Additional Statements/Desires 其他聲明/願望：_____

_____

Organ Donation:
器官捐贈：

Do you want to be an organ, eye and/or tissue donor? (Initial Yes or No) Yes _____ No _____
您想成為器官、眼睛和/或組織捐贈者嗎？（在"是"或"否"處簽署姓名首字母縮寫）是 _____ 否 _____

If yes, circle what you want donated: any organ eye tissue or Specify: _____
如果是，請圈出您想捐贈的器官：任何器官 眼睛 組織 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.

簽名：這是一份法律文檔。透過簽署它，您承認您已仔細審閱，並且它反映了您的願望。您必須年滿18歲才能使用此表格，

Revised 10/20
修訂日期：2020 年 10 月

並且有見證人或公證人見證您簽署此表格。

Sign Your Name 簽名	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
見證人

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.

我在此醫療生前預囑書籤署時在場。此人在簽署此醫療生前預囑時似乎頭腦清晰且沒有被強迫簽署。我還承諾我：1) 已年滿18歲；2) 不是簽署人的醫療決策者；3) 不是簽署人的醫療團隊成員；4) 與簽署人沒有血緣、婚姻或收養關係；以及 5) 在簽署人去世後不會獲得其遺產（如金錢或財產）的任何一部分。

Witness Signature 見證人簽名	Date 日期

Witness Print First Name 見證人正楷名字	Witness Print Last Name 見證人正楷姓氏	Address 地址

This document may be notarized instead of witnessed (optional).
也可以選擇公證而非見證此文檔（可選）

State of Arizona)
亞利桑那州)
County of _____)
_____縣)

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，我親自見證了_____的簽名，其身份得到證明，他/她似乎精神正常，沒有受到脅迫、欺詐或不當影響，並且他/她簽署了上述文檔。

NOTARY PUBLIC 公證人

[Affix Seal Here] [蓋章位置]

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.

我們鼓勵您也完成您的醫療保健授權書。與您的醫療保健授權書持有人、您的醫療提供者以及您所愛的人討論此表格和您對醫療照護的願望。請給他們每人一份此表格的副本。您應該經常審閱此表格並根據需要進行更新。您也可以隨時取消此表格。

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ARIZONA HEALTHCARE POWER OF ATTORNEY WITH OPTIONAL MENTAL HEALTH AUTHORITY

亞利桑那州醫療保健授權書（包括可選的精神健康權利）

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.

此表格讓您在無法溝通或做出這些決定時選擇一個醫療決策者（醫療保健授權書持有人）。醫療決策者必須年滿18歲，應該瞭解您的願望和價值觀，並且是您信任能夠執行您願望的人，可以是您家庭成員或朋友。

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.

通過簽署此表格，您授予您的醫療決策者全面的醫療保健決策權，包括：1) 選擇您的醫療提供者、照護人員、治療方案和您接受照護的地方；2) 同意、拒絕或撤回生命維持或醫療治療。您也可以選擇授予您的醫療決策者做出有關精神健康醫療照護決策的權利；以及 3) 決定您去世后的遺體處理方式，如葬禮安排和器官捐獻（如果您沒有做出其他安排）。

MEDICAL DECISION MAKER - I want this person to make my medical decisions if I am not able to make my own:
醫療決策者 - 如果我不能自己做出決定，我希望此人做我的醫療決策者：

First Name 名字	Last Name 姓氏	Relationship 關係	Phone 電話號碼

Address 家庭地址 _____ Email Address 電子郵箱位址 _____

If the first person cannot do it, then I want this person to make my medical decisions:
如果第一個人不能勝任，我希望此人做我的醫療決策者：

First Name 名字	Last Name 姓氏	Relationship 關係	Phone 電話號碼

Address 地址 _____ Email Address 電子郵箱位址 _____

MENTAL HEALTHCARE POWER OF ATTORNEY - This section must be initialed in front of a witness or a notary.
精神醫療保健授權書 - 此部分必須在見證人或公證人面前簽名。

____ Initial here, to allow your medical decision maker the power to make mental healthcare decisions for you.
在此簽署姓名首字母縮寫，允許您的醫療決策者有權替您做出精神保健醫療照護決策。

____ Initial here, to allow your medical decision maker the power to admit you to an inpatient or partial psychiatric hospitalization program.
在此簽署姓名首字母縮寫，允許您的醫療決策者有權將決定您接受住院或部分精神病住院治療方案。

If there are mental health decisions you do not want them to make, write them here: _____
如果您不希望他們做出某些精神健康醫療決定，請在此寫明：_____

This section may not be revoked if you are not able to make decisions for yourself, as determined by your physician.
如果您的醫生確定您無法自主做出決定，則此部分不能撤銷。

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.***

這是一份法律文檔。透過簽署它，您承認您已仔細審閱，並且這些內容反映了您的願望，即誰能做您的醫療決策者、這些決策應該是什麼，並且這些願望應得到尊重。***為了使此表格有效，您必須年滿 18 歲，並且有見證人或公證人見證您簽署此表***

格。

Sign Your Name 簽名 | 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
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State of Arizona)
亞利桑那州)
County of _____)
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