

預立醫囑

(Advance Directive)

什麼是預立醫囑？

What is an advance directive?

預立醫囑是由您填寫以確保自身獲得所需醫療保健的法律文件。在預立醫囑中，您可以選擇在自身無法做出醫療保健決定時代您做決定的人員。此人就是您的醫療保健代理人。您還可以在文件中說明有關在病重時自己希望以及不希望接受的醫療和其他照護。

An advance directive is a legal document you complete to make sure you get the healthcare you want. In an advance directive, you can choose someone to make healthcare decisions for you, if you are ever unable to make them yourself. This person is called your healthcare agent. You also can give information about the medical treatments and other care you would and would not want if you became very sick.

每位成年人都應該要立一份預立醫囑，年長者或患有重病者尤為需要。填寫預立醫囑讓您可以知道自己的價值觀和目標將得到尊重，這還能讓您的醫療保健代理人完全知曉在需要為您做出醫療決定時他們該怎麼做。

Every adult should have an advance directive. It is especially important for adults who are older or have serious illnesses. Completing an advance directive helps you know that your values and goals will be honored. It also gives your healthcare agent the peace of mind of knowing what you would want them to do if they need to make healthcare decisions for you.

預立醫囑僅涉及醫療決定。您必須填寫其他文件才能授權他人處理您的財務或財產狀況。

An advance directive only deals with healthcare decisions. You must complete a different document to give someone authority to handle your finances or property.

名字
First Name

姓氏
Last Name

出生日期
Date of Birth



資訊與指示

Information and Instructions

我該如何填寫這份預立醫囑？

How do I complete this advance directive?

我們建議您填妥整份表格，不過也可以只填寫其中的一部分。對於您不想填寫的任何部分劃掉即可。最好與您的醫療保健代理人（如果您選擇指定一名代理人）和親人一起填寫這份表格，以便他們可以清楚地瞭解您的首選決定。醫生、護士、社工、牧師或其他醫療保健專業人員也可以為您提供協助。

We encourage you to complete the entire form, but it is okay if you only want to complete part of it. Just cross out any parts you do not want to fill out. It is a good idea to complete this form with your healthcare agent (if you choose to name one) and loved ones so they clearly understand your preferences. A doctor, nurse, social worker, chaplain, or other healthcare professional also can help you.

在第 1 部分：選擇做決定者，您指定一名醫療保健代理人。此人為您信任並且會在您無法做出醫療保健決定時代您做決定的人。您可以選擇一名主要醫療保健代理人 and 最多兩位候補（順位）醫療保健代理人。

In **PART 1: Choosing A Decisionmaker**, you name your healthcare agent. This is the person you trust to make your healthcare decisions for you if you are ever unable to make them yourself. You choose one primary healthcare agent and up to two alternate (backup) healthcare agents.

最好先與您的醫療保健代理人進行充分溝通後，再將其列入本表格。要確認對方願意提供協助，並看看他們是否對您的醫療保健首選決定有任何疑問。務必選擇您信任的醫療保健代理人來代您做決定。這是因為他們將根據您在表格其餘部分提供的資訊，與您的醫療保健團隊一起做出決定。如果您擔心指定的醫療保健代理人不會遵守您的意願，則您應該考慮其他人選。

It is a good idea to talk with your healthcare agent before you list them on this form. Make sure they are willing to help and see if they have any questions about your healthcare preferences. It is very important to choose a healthcare agent you trust as your decisionmaker. It will be up to them to make decisions with your healthcare team based on the information you provide in the rest of the form. If you are worried that your healthcare agent will not follow your wishes, you should consider choosing someone else.

資訊與指示 [續]

Information and Instructions [continued]

理想的醫療保健代理人應符合以下條件：

A good healthcare agent:

- ✓ **年滿 18 歲**
Is 18 years old or older
- ✓ **非常瞭解您**
Knows you well
- ✓ **明白什麼對您而言很重要**
Understands what's important to you
- ✓ **方便醫療保健團隊與其聯絡（親訪、打電話、透過口譯人員接洽等）**
Is easy for the healthcare team to contact (in person, by phone, through an interpreter, etc.)
- ✓ **能在壓力下做出正確的決定**
Makes good decisions under pressure

您的醫療保健代理人不得為以下人選：

Your healthcare agent cannot be:

- ✗ **未滿 18 歲者**
Under 18 years old
- ✗ **您的醫生、護理人員或醫師助理***
Your doctor, nurse practitioner, or physician assistant*
- ✗ **您目前所在照護醫院的員工***
An employee of the hospital where you are receiving care*
- ✗ **您獲得照護之社區照護機構或安養機構的擁有者或經營者**
The owner or operator of a community care facility or residential care facility where you receive care
- ✗ **超過 10 名醫療保健代理人**
The healthcare agent for more than 10 other people

在**第 2 部分：我的醫療保健首選決定**，您要寫下自己的醫療保健首選決定，以便於您的醫療保健代理人明白您希望他們做出的選擇。這包括對您而言有意義的生活品質是什麼樣的，以及您希望以及不希望接受的醫療和其他照護。

In **PART 2: My Healthcare Preferences**, you write down your healthcare preferences, so your healthcare agent understands the choices you want them to make. This includes what a meaningful quality of life looks like for you and what medical treatments and other care you do and do not want.

在**第 3 部分：簽名及完成**，您要在兩名見證人或公證人面前簽署**預立醫囑表格。按照第 3 部分中的指示填妥表格後，這份表格就會變成具有加州法律約束力的文件。第 3 部分還給出了填妥本表格後該如何處理的指示。

In **PART 3: Sign and Complete**, you sign** the advance directive form either in front of two witnesses or a notary public. Once you fill out the form and follow the instructions in Part 3, this will be a legally binding form in the state of California. Part 3 also gives instructions for what to do with this form after it is completed.

第 4 部分：我的價值觀，可選擇性填寫，您可以在此部分告知醫療保健團隊和親人於您而言重要的事項。這包括您精神上的喜好、便於您長期住院的支援，以及臨終前想要實現的願望。在第 4 部分中，請告訴您的代理人、醫療保健團隊和親人您心中的理想照護是什麼樣子的。

PART 4: My Values is an optional section where you can tell your healthcare team and loved ones what else matters to you. This includes your preferences about spirituality, what would make a long hospital stay easier for you, and what you want to happen in your final days. Part 4 lets your agent, healthcare team and loved ones know what excellent care looks like for you.

* 如果此人是您的家庭成員或同事，則以上限制並不適用。

These restrictions do not apply if this person is your family member or coworker.

** 如果您因身體之故而無法簽名，您可以選擇讓另一名成年人在您的指示下及您在場的情況下代您簽名。

If you are physically unable to sign, you may select another adult to sign at your direction and in your presence.

第 1 部分：選擇做決定者

PART 1: Choosing a Decisionmaker

醫療保健持久委任書

Durable Power of Attorney for Healthcare

如果我無法自己做決定，我的醫療保健代理人將能代我：

If I am unable to make decisions for myself, my healthcare agent will be able to:

- 決定我接受或不接受哪些醫療和程序，包括人工維生系統。
Decide which medical treatments and procedures I do or do not receive, including artificial life support.
- 選擇參與我的照護的醫療保健提供者和機構。
Choose which healthcare providers and facilities are involved in my care.
- 查看我的病歷並接收有關我目前病情的資訊。
See my medical records and receive information about my current medical status.
- 代表我配合健康保險公司或其他醫療保健計畫的工作。
Work with health insurance companies or other healthcare programs on my behalf.
- 指示我去世後遺體的處置。
Direct the disposition of my remains after my death.

我希望此人成為我的主要醫療保健代理人。在我無法自行做出決定時，此人將代我做出醫療保健決定：

I want this person to be my PRIMARY HEALTHCARE AGENT. They will make my healthcare decisions if I cannot make them for myself:

姓名 Name	電話號碼 Phone Number		
地址 Address	城市 City	州 State	郵遞區號 ZIP
關係 Relationship	電子郵件地址 Email Address		

我希望此人成為我的第一候補醫療保健代理人。在我無法自行做出決定且我的主要醫療保健代理人亦不在場時，此人將代我做出醫療保健決定：

I want this person to be my FIRST ALTERNATE HEALTHCARE AGENT. They will make my healthcare decisions if I cannot make them for myself and my primary healthcare agent is unavailable:

姓名 Name	電話號碼 Phone Number		
地址 Address	城市 City	州 State	郵遞區號 ZIP
關係 Relationship	電子郵件地址 Email Address		

第 1 部分：選擇做決定者 [續]

PART 1: Choosing a Decisionmaker [continued]

我希望此人成為我的第二候補醫療保健代理人。在我無法自行做出決定且我的其他醫療保健代理人亦不在場時，此人將代我做出醫療保健決定：

I want this person to be my SECOND ALTERNATE HEALTHCARE AGENT. They will make my healthcare decisions if I cannot make them for myself and my other healthcare agents are unavailable:

姓名 Name	電話號碼 Phone Number		
地址 Address	城市 City	州 State	郵遞區號 ZIP
關係 Relationship	電子郵件地址 Email Address		

選擇性填寫

Optional

如果您希望自己的醫療保健代理人能夠立即代您做出決定，請在填妥這份表格後，勾選以下方框。否則，只有在您自己無法做出決定時，他們才能代您做決定。

If you want your healthcare agent to be able to make decisions for you right now, after you complete this form, check the box below. Otherwise, they will only be able to make decisions for you if you are not able to make them yourself.

- ☐ 我希望我的醫療保健代理人能夠立即代我做決定。不過，我知道我可以隨時告知我的醫療保健提供者我不再希望我的醫療保健代理人代我做決定。

I want my healthcare agent to be able to make decisions for me right now. However, I understand that I can tell my healthcare provider at any time that I no longer want my healthcare agent to make decisions for me.

選擇性填寫

Optional

在您的醫療保健代理人履行您的醫療心願方面，您還可以選擇給予他們多大的彈性。（請勾選一項）：

You also can choose how much flexibility to give your healthcare agent in carrying out your medical wishes. (Check one):

- ☐ 我的醫療保健代理人應完全按照我在預立醫囑中寫下的指示，即使相關指示會令他們感到不舒服。

My healthcare agent should follow my instructions exactly as I have written them in this advance directive, even if it makes them uncomfortable.

- ☐ 當我的醫療保健代理人認為有最合適我的醫療決定時，他們可以更改我的決定。對於某些我不想被更改的決定，我已經填寫在下方。

My healthcare agent can change my medical decisions if they think it would be best for me. If I have certain decisions I never want changed, I have written them below.

第 2 部分：我的醫療保健首選決定

PART 2: My Healthcare Preferences

生前遺囑/醫療保健指示

Living Will/Healthcare Directive

人工維生系統

Artificial Life Support

如果您病況嚴重，醫生可能會提供人工維生系統。這包括呼吸器（呼吸裝置）、人工營養（餵食管）以及其他讓您在自然死亡後維持生命的藥物或機器等治療。人工維生系統能讓其他治療方法有時間奏效，但是其本身並不能幫助您改善身體狀況。

If you are seriously ill, your doctors may offer artificial life support. This includes treatments like a ventilator (breathing machine), artificial nutrition (feeding tube), and other medications or machines that keep you alive past the point when you would have died naturally. Artificial life support gives other treatments time to work but does not help you get better by itself.

如果我病重到需要人工維生系統來維持生命（請勾選一項）：

If I am so sick that I need artificial life support to keep me alive (Check ONE):

☐ 我希望盡可能長時間地接受人工維生系統的治療，即使這不可能或者很難讓我康復到能夠過上有意義的生活。

I want to receive artificial life support for as long as possible, even if there is little or no chance of recovering to live a life that is meaningful for me.

☐ 如果有很大的機會讓我能夠康復到過上有意義的生活，我希望接受人工維生系統的治療。但是，如果我的醫生認為我無法康復，則我希望停止使用維生系統、專心接受安寧照護並讓我能自然死亡。

I want to receive artificial life support if there is a good chance of recovering to live a life that is meaningful for me. But, if my doctors do not think I will recover, I want to stop life support, focus on being comfortable, and be allowed to die a natural death.

☐ 我絕對不接受人工維生系統的治療。如果我病重到需要人工維生系統來維生，我希望專心接受安寧照護並讓我能自然死亡。

I never want artificial life support. If I become so sick that I need life support to keep me alive, I want to focus on being comfortable and be allowed to die a natural death.

☐ 我想將這項決定交由我的醫療保健代理人和我的治療團隊來處理。

I want to leave it up to my healthcare agent and my treatment team.

以上是有關我的醫療保健的其他特定指示（例如，是否有我絕不希望接受的特定治療方法或者我絕不希望使用人工維生系統的特定情況）：

These are other specific instructions regarding my healthcare (for example, if there are specific treatments I would never want, or certain situations when I would never want artificial life support):

第 2 部分：我的醫療保健首選決定 [續]

PART 2: My Healthcare Preferences [continued]

生活品質

Quality of Life

務必必要讓您的醫療保健代理人和您的醫療保健團隊知道什麼才是對您而言有意義的生活。有了這些資訊，他們便能確保您的治療計畫符合您的目標。

It is important for your healthcare agent(s) and your healthcare team to know what makes life meaningful for you. With this information, they can make sure your treatment plan meets your goals.

對我而言，我的生活只有在實現以下自由的情況下才有意義（請勾選所有適用選項）：

For me, my life is only meaningful if I can (Check all that apply):

- ☐ **無需永遠依靠機器就能生活**
Live without being permanently hooked up to a machine
- ☐ **認得家人和朋友**
Recognize family and friends
- ☐ **跟家人和朋友溝通交流**
Communicate with family and friends
- ☐ **生活中無嚴重疼痛或不適**
Live without severe pain or discomfort
- ☐ **能夠起身下床**
Get out of bed
- ☐ **行動夠自如，可以外出（走路、坐輪椅等）**
Move well enough to leave my home (walk, use a wheelchair, etc.)
- ☐ **吃自己最愛食物**
Eat my favorite food
- ☐ **洗澡並能照顧好自己**
Bathe and take care of myself
- ☐ **頭腦清楚，知道身邊發生的事情**
Think clearly enough to know what is going on around me
- ☐ **住在自己家裡**
Live in my own home
- ☐ **做自己最喜歡的事情：** _____
Do my favorite hobby:

或者 (OR)

- ☐ **以上都不是。不管我病得有多重，我的生活總是有意義的。**
None of the above. My life is always worth living no matter how sick I am.

或者 (OR)

- ☐ **我不確定。**
I am not sure.

以下事情也會讓我生活的變得有意義：

These things also are very important for me in living a meaningful life:

第 3 部分：簽名及完成

PART 3: Sign and Complete

請先仔細閱讀這部分的全部內容再進行簽名。

Read this entire section carefully before signing.

在加州，讓這份表格具有法律效力的方法有兩種。您只需選擇以下的一項即可。

In California, there are two ways to make this form legal. You only need to choose ONE of the options below.



選項 1

OPTION 1

請在兩名見證人面前簽名*，然後讓見證人簽署表格。當您的見證人在表格上簽名時，他們要保證簽署這份預立醫囑者確實是您本人，而且沒有人強迫您簽名。

Sign in front of two witnesses, and then have your witnesses sign the form. When your witnesses sign the form, they are promising that it is really you that is signing this advance directive and that nobody is forcing you to sign.*

您的見證人必須年滿 18 歲。

Your witnesses must be at least 18 years old.

您的見證人不得為以下人選：

Your witnesses must not be:

*** 這份表格中指定的醫療保健代理人或候補代理人**

A healthcare agent or alternate agent designated in this form

*** 您的醫療保健提供者**

Your healthcare provider

*** 您居住或接受醫療保健之授權機構的任何擁有者、經營者或員工**

Anyone who owns, operates, or works at a licensed facility where you live or receive healthcare

只有一名見證人可以與您有親戚關係或被納入到您的遺囑中。

Only one of your witnesses may be related to you or be included in your will.

如果您使用證人，请在表格上签字并让您的证人签字。

If you are using witnesses, sign the form and have your witnesses sign.



選項 2

OPTION 2

在公证人面前签名*。要公证此表格，您需要提供政府签发的带照片的有效身份证件（例如驾照或护照）。如果您委托公证人，请在表格上签名并请公证人完成确认。

Sign in front of a notary public. To have this form notarized, you will need current, government-issued photo identification (like a driver's license or passport). If you are using a notary, sign the form and have the notary complete the acknowledgment.*

* 如果您因身體之故而無法簽名，您可以讓另一名成年人在您在場的情況下代您簽名。

If you are unable to physically sign, you may have another adult sign in your presence and on your behalf.

第 3 部分：簽名及完成 [續]

PART 3: Sign and Complete [continued]

請等到您與兩名見證人或一名公證人到齊後，再於下方簽名。

WAIT until you are with your two witnesses or a notary, then sign below.

您的簽名

YOUR SIGNATURE

簽名
Signature

日期
Date

姓名（以正楷填寫）
Name (Printed)

電話號碼
Phone Number

地址
Address

城市
City

州
State

郵遞區號
ZIP



選項 1 – 見證

OPTION 1 – Witnesses

如果您在見證這份文件，請閱讀以下聲明。如果您同意這份聲明，請在下方簽名。見證人聲明：我聲明，如以下情況不實，根據加州法律，我將受偽證罪懲處：

If you are witnessing this document, read the following statement. If you agree with the statement, sign below. STATEMENT OF WITNESSES: I declare under penalty of perjury under the laws of California that

(1) 簽署/確認這份預立醫囑者是我個人認識的人或者我已依據有力證據證明其身分；

The individual who signed/acknowledged this advance directive is personally known to me or that their identity was proven to me by convincing evidence;

(2) 當事人在我在場的情況下簽署或確認了這份預立醫囑；

The individual signed or acknowledged this advance directive in my presence;

(3) 當事人看起來心智健全，並且沒有受到任何脅迫、欺詐或不當影響；

The individual appears to be of sound mind and under no duress, fraud, or undue influence;

(4) 我不是這份預立醫囑指定的代理人；並且

I am not a person appointed as agent by this advance directive; and

(5) 我不是當事人的醫療保健提供者、當事人醫療保健提供者的員工、社區照護機構的經營者、社區照護機構的經營者員工、安養機構的經營者或安養機構經營者的員工。

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.

第 3 部分：簽名及完成 [續]

PART 3: Sign and Complete [continued]

第一名見證人：

First Witness:

簽名 Signature	日期 Date		
姓名（以正楷填寫） Name (Printed)	電話號碼 Phone Number		
地址 Address	城市 City	州 State	郵遞區號 ZIP

第二名見證人：

Second Witness:

簽名 Signature	日期 Date		
姓名（以正楷填寫） Name (Printed)	電話號碼 Phone Number		
地址 Address	城市 City	州 State	郵遞區號 ZIP

無論見證人是上述中的哪一名，其也必須仔細閱讀以下聲明並在下方簽名：

One of the two witnesses also must read the following statement carefully and sign below:

見證人附加聲明：

ADDITIONAL STATEMENT OF ONE WITNESS:

我進一步聲明，如以下情況不實，根據加州法律，我將受偽證罪懲處：我與執行這份預立醫囑的當事人沒有血親、姻親或收養關係，並且據我所知，根據現有遺囑或法律規定，我在當事人去世後無權獲得其任何財產。

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance 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.

簽名 Signature

第 3 部分：簽名及完成 [續]

PART 3: Sign and Complete [continued]



OPTION 2 - Notarization

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 that document.

STATE OF CALIFORNIA

County of _____

On _____ before me _____,

personally appeared _____,

who proved to me 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.

Notary Public Seal

Notary Public Signature



選項 2 - 公證

OPTION 2 - Notarization

填寫這份證書的公證人或其他官員，僅會驗證簽署這份證書所附文件的當事人身分，而不會驗證這份文件的真實性、準確性或有效性。

加州

郡：

於

在我面前

，親自在場者

，以符合要求的證據向我證明了其就是在這份文書上簽名之人，同時承認其以授權身分執行這份文書，並且憑藉這份文書上的簽名，當事人或當事人所代表的實體執行了這份文書。

我證明以上資料均正確無誤，否則根據加州法律，我將受偽證罪懲處。

公證人親筆簽名並蓋章。

公證人簽名

公證人蓋章

第 3 部分：簽名及完成 [續]

PART 3: Sign and Complete [continued]

僅適用於專業護理機構住院者的附加要求

Additional Requirement Only for Residents of Skilled Nursing Facilities

只有當您是專業護理機構的患者時，才需要填寫以下聲明 — 專業護理機構是指提供以下基本服務的醫療機構：專業護理和支持性照護，對象為需要長期接受專業護理的患者。如果您是在其他地方（例如醫院、醫生辦公室或家中）填寫這份表格，則不需要填寫此部分。患者倡議者或權利維護者必須簽署以下聲明：

The following statement is required only if you are a patient in a skilled nursing facility—a health care facility that provides the following basic services: skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. If you are completing this form in another location, like a hospital, doctor's office, or your home, this section is not required. The patient advocate or ombudsman must sign the following statement:

患者倡議者或權利維護者聲明：本人聲明，本人是州年長者服務部 (State Department of Aging) 指定的患者倡議者或權利維護者，並且根據《遺囑檢驗法典》(Probate Code) 第 4675 條的規定擔任見證人。如上述情況不實，根據加州法律，我將受偽證罪懲處。

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.

簽名
Signature

日期
Date

姓名（以正楷填寫）
Name (Printed)

電話號碼
Phone Number

後續步驟

Next Steps

恭喜！

Congratulations!

您已經填妥您的預立醫囑。接下來是後續步驟：

You have completed your advance directive. Here's what to do next:

- **把這份文件帶回家並放在安全的地方，以便於親人在有需要時拿取。**
Take this document home and keep it somewhere safe where your loved ones can easily access it if needed.
- **印出來提供給您的醫療保健代理人、您的醫生以及您接受治療之任何醫院或機構。這份文件的複本與正本同樣有效。**
Make copies and give them to your healthcare agents, your doctor, and any hospital or facility where you receive treatment. Copies of this document are just as valid as the original.
- **與您的家人、醫療保健代理人、醫生和其他醫療保健提供者討論您的預立醫囑。確保他們瞭解什麼對您的醫療保健很重要。**
Talk with your family, healthcare agents, your doctors and other healthcare providers about your advance directive. Make sure they understand what's important for your healthcare.
- **如果您擁有 MyChart 帳戶，您可以上傳這份預立醫囑。請造訪 www.memorialcare.org/acp 獲得更多資訊。**
If you have a myChart account, you can upload this advance directive. For more information go to www.memorialcare.org/acp.
- **如果您想提供更多資訊，您可以填寫「第 4 部分 – 我的價值觀」。**
If you want to provide more information, complete Part 4 – My Values.

以下是更新或變更預立醫囑的方法：

Here's how to update or change your advance directive:

- **如果您在醫院時對這份預立醫囑所寫的任何內容改變主意，請務必告知您的醫生，並讓他們在您的病歷中記錄任何變更。**
If you change your mind about anything you have written in this advance directive while you are in the hospital, make sure to tell your doctor and have them document any changes in your medical record.
- **在您與兩名見證人或一名公證人簽署本文件後，這份預立醫囑會始終維持有效，直到您撤銷為止。如果您想撤銷這份預立醫囑，您可以在文件正面用大寫字母寫下「REVOKED」（撤銷）並簽名或告知您的主治醫生。如果您填寫新的預立醫囑，則先前的版本就會自動撤銷。**
Once you have signed this document with two witnesses or a notary, this advance directive is valid until you revoke it. If you want to revoke this advance directive, you can either write "REVOKED" in large letters across the front of the document and sign it or tell your primary doctor. If you complete a new advance directive, it will automatically revoke any previous advance directives.
- **請務必將最新版文件提供給您的家人、醫療保健代理人、醫生，並放到先前存放預立醫囑的其他地方。**
Make sure to provide the updated documents to your family, healthcare agents, your doctor, and anywhere else your previous advance directive was stored.
- **時光荏苒，物換星移。雖然這份預立醫囑並不會到期，但最好還是審閱一下，看看是否需要更新：**
As time goes on, things change. This advance directive does not expire, but it is a good idea to review it and see if it needs updating:
 - **每 10 年一次**
Every 10 years
 - **在您結婚或離婚時**
If you get married or divorced
 - **在您被診斷出患有新的疾病時**
If you are diagnosed with a new health condition
 - **在您健康狀況下滑時**
If your health declines
 - **親人去世之後**
After the death of a loved one

第 4 部分（選擇性填寫）：我的價值觀

PART 4 (Optional): My Values

良好的醫療保健不僅在於藥物治療。請在這份預立醫囑的選擇性補充內容中，告知親人和您的照護團隊，當您病重時，什麼才是對您最重要的事。請在這個部分儘量詳細或精簡填寫自己的心願。如果您選擇填寫這部分，請將其與預立醫囑的其餘部分一起保存。

Good healthcare is about more than medical treatment. In this optional addition to your advance directive, tell your loved ones and your care team what is most important to you if you become seriously ill. Complete as much or as little of this section as you want. If you choose to complete this section, keep it attached to the rest of your advance directive.

當我病重時

When I am Seriously Ill

- ☐ **即使止痛藥讓我困得無法保持清醒，我希望能保持舒適及免受痛苦。**
I want to be kept comfortable and free from pain, even if my pain medicine makes me too sleepy to stay awake.
- ☐ **我希望我的家人和親人來看我並與我說說話。**
I want my family and loved ones to visit me and talk with me.
- ☐ **希望得到溫柔的撫觸（握手、撫摸我的頭髮等）。**
Comforting touches (handholding, stroking my hair, etc.) are welcome.
- ☐ **我希望聽到我最喜歡的音樂。我最喜歡的音樂包括：** _____
I want my favorite music to be played. My favorite music includes:
- ☐ **如果可以的話，我希望自己能夠參與做治療決定。我希望我的治療團隊能與我交談，並告知我他們的治療程序，即使我意識不清。**
If I am able, I want to be involved in making my own treatment decisions. I want my treatment team to talk to me and tell me what they are doing, even if I don't seem aware.

如果可以的話，我想在自己的房間裡做以下事情：

If possible, I would like the following things in my room:

如果精神生活和/或宗教對我很重要，則我的照護團隊應該要知道：

If spirituality and/or religion is important to me, here is what my care team should know:

如果我病得很重，請確保「不要」發生以下情況：

If I am very sick, I want to make sure the following things DO NOT happen:

如果我病得很重，請確保「一定要」實現以下事項：

If I am very sick, I want to make sure the following things DO happen:

第 4 部分（選擇性填寫）：我的價值觀 [續]

PART 4 (Optional): My Values [continued]

臨終前

At the End of Life

如果可以的話，我想這樣度過最後那些日子：

If possible, I would like to spend my final days:

☐ **待在家裡**
At home

☐ **待在醫院**
In the hospital

☐ **待在養護中心或其他機構**
At a nursing home or other facility

☐ **其他：** _____
Other:

☐ **無偏好**
No preference

如果可以的話，我希望我的遺體可以：

If possible, I would like my remains to be:

☐ **埋葬**
Buried

☐ **火化**
Cremated

☐ **其他：** _____
Other:

以下是我對自己葬禮或追思會的具體心願：

These are my specific wishes for my funeral or memorial service:

我希望家人和親人知道：

I want my family and loved ones to know: