HUMENSIA
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DESIGNATION OF A TRUSTED PERSON IN HAD

Article L.1111-6 of the French Public Health Code **:** *« Any adult may designate a trusted person, who may be a relative, a close friend, or the attending physician, and who will be consulted in the event that the individual is unable to express their wishes and receive the necessary information for this purpose. The trusted person shall report the individual's will. Their testimony takes precedence over any other testimony. This designation must be made in writing and co-signed by the person designated. It may be revised or revoked at any time. If the patient so wishes, the trusted person may accompany them in administrative procedures and attend medical consultations to assist them in decision-making.*

Upon any hospitalization in a healthcare facility, the patient must be offered the possibility to designate a trusted person under the conditions set out in this article. This designation is valid for the duration of the hospitalization, unless the patient decides otherwise. As part of patient care, the attending physician shall ensure the patient is informed of the possibility to designate a trusted person and, where appropriate, encourage them to make such a designation. When a person is placed under guardianship (as defined in Chapter II of Title XI of Book I of the French Civil Code), they may designate a trusted person with authorization from the judge or the family council, if one has been established. If the trusted person was designated prior to the guardianship, the family council, if applicable, or the judge may confirm or revoke this designation. »

Pursuant to the provisions outlined above, I, the undersigned :

Mr / Mrs (1), Last Name (2) : ..... First Name (2) : .....

Date of Birth (2) : ..... Residence Address (2) :.....

.....

Hereby designate as my trusted person :

Mr / Mrs (1), Last Name (2) : .....First Name (2) : .....

Relationship : ☐ Family(3) ☐ Close friend (3) ☐ Attending physician (3)

Address (2) : .....

....., Phone number (2) :.....

This designation applies :

- ☐ only for the current care episode (3) ;
- ☐ For all future care episodes (3).

I reserve the right to modify, supplement, or revoke this designation at any time.

I commit to informing the designated person of this appointment and confirm their agreement by obtaining their signature on this document.

Done in ....., on .....

Signature : Signature of the trusted person :

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Association à but non lucratif engagée pour la santé, les soins et l'accompagnement à domicile depuis 1955

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Role of the Trusted Person :

- To accompany you and attend medical consultations,
- To help you make decisions,
- To speak on your behalf (not their own), especially in situations where you may feel overwhelmed or hesitant; the trusted person may ask questions you would have wished to ask and can receive explanations from the physician to relay back to you,
- To be consulted before any decision, examination, intervention, or treatment is undertaken by the physician managing your care,
- To know and represent your wishes and ensure they are respected.

Form handed to :

Last Name	First Name	Relationship (physician, family, friend)	Address	Phone Number

I, the undersigned, Mr / Mrs [(1)], Last Name [(2)] :.....
First Name [(2)] :..... hereby confirm that I have read this document on [(1)] ....., **and don't wish to appoint a trusted person**.

I understand that this decision is revocable at any time, and I agree to inform the relevant department if I change my mind.

Done in ....., on .....

Signature :

SELECTION RESERVED FOR HAD PROFESSIONALS

☐ The patient is unable to receive the information and/or designate a trusted person [(3)].
☐ The patient chose not to complete this document [(3)].

Name : ....., First Name : ....., Position :.....
Done in....., On.....

Signature of HAD professional :

[[(1)] Delete as appropriate] [[(2)] Fill in] [[(3)] Tick the appropriate box]

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