Advance Directive

Durable Power of Attorney (DPOA) for Health Care
Health Care Directive

Documents are legally valid in Washington

What is advance care planning?

Advance care planning is for all adults 18 and older. It is talking about future health care decisions if you had a sudden event, like a serious accident or illness, and could not make your own decisions. A person close to you would need to make choices for you. This person is called a health care agent or attorney in fact.

It is important to write down your goals, values, and preferences using the following documents or documents like them. These documents, called advanced directives, should be updated regularly and shared with your health care agent, loved ones, physician, and hospital. You may complete one or both documents.

Durable Power of Attorney for Health Care.
Preparing a Health Care Agent. Describe your personal values and goals for treatment. This information can guide your health care agent and health care providers to make the best possible decisions on your behalf if you cannot make decisions for yourself in the future.

Naming a Health Care Agent. Choose a health care agent to make medical decisions for you if you cannot make them for yourself.

Health Care Directive. Choose whether you want life-sustaining treatments in certain situations.

Ask your doctor if you should also complete a physician order for life sustaining treatment (POLST). A POLST is a medical order that is used to communicate medical care decisions to health care providers and emergency responders. It may be appropriate for you if you are seriously ill or frail now.

For more information and additional resources, go to **www.HonoringChoicesPNW.org**.

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Advance Directive

Durable Power of Attorney for Health Care – Preparing a Health Care Agent

In completing this form, I am sharing my health care wishes. If the time comes when I cannot make medical decisions for myself, I want these wishes to be followed. I understand that this document will help guide my care, but it might not be possible to follow these wishes exactly in every situation.

What matters the most to me?

This section helps you think about and communicate what matters to you if you ever have a serious accident or illness and cannot make medical decisions for yourself.

To me, "living well" or "a good day" means that I am able to: (choose all that apply)

- ☐ Communicate with my family and friends
- ☐ Know who I am or who I am with
- ☐ Be free of or have minimal pain
- ☐ Physically and mentally do the things I love
- ☐ Feed, bathe, and take care of myself
- ☐ Live without life-sustaining treatment
- ☐ See my loved ones reach milestones

The following is what "living well" or "a good day" means to me in my own words.

_____

_____

_____

_____

_____

Durable Power of Attorney for Health Care – Preparing a Health Care Agent

If I am dying, I would like to be:

- ☐ At home, if care is available.
- ☐ In a hospital or skilled nursing facility.
- ☐ It does not matter to me.

Religious, Spiritual, or Personal Beliefs

The following beliefs are important to me, including medical treatment that I want or do not want based on my beliefs.

_____

_____

_____

_____

_____

I would want the following person contacted:

Name: _____ Profession: _____

Phone number: _____ Place of Worship: _____

What is life-sustaining treatment?

Life-sustaining treatment (or life-support) can keep you alive by maintaining or replacing important bodily functions like breathing using a machine. Some examples of life-sustaining treatment are cardiopulmonary resuscitation (CPR), breathing machines, feeding tubes, and kidney dialysis.

Life-sustaining treatment may be used temporarily until a patient's body can function on its own. In other situations, life-sustaining treatments can prolong the dying process without the possibility to be cured. Easing pain and providing comfort are part of routine care and *are not* considered life-sustaining treatments.

For more information, go to: **www.HonoringChoicesPNW.org**.

Durable Power of Attorney for Health Care – Preparing a Health Care Agent

My Wishes

Imagine this scenario: A sudden event (such as a car accident or illness) left you unable to communicate. You are getting all the care needed to keep you alive and comfortable. The doctors believe there is little chance you will recover the ability to know who you are or who you are with.

I want my health care providers and health care agent to do the following:

◯ Continue medical treatment to keep me alive, even if there is little chance of getting better.

☐ Exception: Do not try the following medical treatments (e.g. breathing machine, feeding tube, kidney dialysis):

_____

_____

◯ Stop medical treatment to keep me alive and allow a natural death while keeping me comfortable.

◯ I want my health care agent to decide for me.

Cardiopulmonary Resuscitation (CPR) Preference:

◯ I want CPR attempted if my heart or breathing stops.

◯ I want CPR attempted if my heart or breathing stops, unless I have any of the following:*

- A disease or injury that cannot be cured, and I am dying; or
- Little chance of survival if my heart stops; or
- Little chance of any long-term survival if my heart stops and the efforts to bring me back to life would cause me suffering; or
- Little chance of returning to the quality of life I wish for and have already discussed with my health care agent.

◯ I do not want CPR attempted if my heart or breathing stops, and instead I want to die naturally.*

* Ask your doctor if you should also complete a physician order for life sustaining treatment (POLST). A POLST is a medical order that is used to communicate medical care decisions to health care providers and emergency responders.

Pregnancy

A "Health Care Directive" (see next section) is not enforceable if your physician knows you are pregnant.

If I am pregnant and cannot make medical decisions for myself, I would like my health care agent and health care providers to take the following into consideration as they make medical decisions on my behalf:

Additional Directions

Write any additional information you want your health care providers, health care agent, or others to know about your health care wishes.

Durable Power of Attorney for Health Care – Naming a Health Care Agent

What is a health care agent?

A health care agent is the person you choose to make medical decisions for you if you cannot make them for yourself. You authorize this person to make decisions with your health care providers about your care. The information below will help you select a health care agent.

What will happen if I do not choose a health care agent?

If you cannot make medical decisions for yourself and do not choose a health care agent, your doctors will follow your state's law to find a decision-maker for you. This probably means they will ask your closest family members to make decisions or ask the court to appoint a legal guardian.

Who should I select as my health care agent?

There are several things to think about when making this decision. Your health care agent:

- Must be at least 18 years or older.
- Must not be any of your physicians or your physician's employees.
- Must not be an owner, administrator, or employee of a health care facility or long-term care facility where you receive care or live (unless they are your spouse, state registered domestic partner, father, mother, or your adult child, brother, or sister).
- Should understand what a health care agent does and be willing to do this role.
- Should be able to talk on your behalf about your goals, values, and preferences and what "living well" or a "good day" means to you.
- Should carry out your decisions (even if they do not agree with the decisions).
- Should be able to make decisions in difficult or stressful times.

What kind of decisions can my health care agent make on my behalf?

Your health care agent will need to follow the health care choices you have made on your advance directive.

Consistent with your choices and state law, your health care agent can:

- Give permission to perform or withhold cardiopulmonary resuscitation (CPR), breathing machine, feeding tube, and other treatments.
- Give permission for treatments and surgeries to treat your conditions.
- Review and authorize the release of medical records as needed for your care and/or for application for health care insurance benefits.
- Decide which health care providers and organizations may provide your medical treatment.
- Interpret any instructions and decisions you have provided in your advance directive or given in other discussions based on their understanding of your wishes and values.

Durable Power of Attorney for Health Care – Naming a Health Care Agent

The person I designate as my health care agent is:

Full Name: _____

Relationship to me: _____

Home Phone: _____

Cell Phone: _____

Address: _____

City/State/ZIP: _____ Email Address: _____

Alternate Agents

If the person listed above:

- Is not able, willing, or available, or
- Has divorced or legally separated from me and I have not initialed the space below, or
- Has died.

Then, I designate the people listed below as my first and second alternate choices:

1st Alternate – Full Name: _____

Relationship to me: _____

Home Phone: _____

Cell Phone: _____

Address: _____

City/State/ZIP: _____ Email Address: _____

2nd Alternate – Full Name: _____

Relationship to me: _____

Home Phone: _____

Cell Phone: _____

Address: _____

City/State/ZIP: _____ Email Address: _____

Durable Power of Attorney for Health Care – Naming a Health Care Agent

Initial the line below if you agree with this statement.

_____ If my spouse or domestic partner is my health care agent, I want them to continue as my health care agent even if our marriage or domestic partnership ends through a dissolution, annulment, or termination.

Initial the line below if this situation applies to you.

_____ I do not have a health care agent. I understand that if no health care agent is appointed and I am unable to make my own medical decisions, my health care providers may need to ask a court to appoint a guardian who can then use my advance directive for guidance to make decisions on my behalf.

Statement of General Authority and Powers of My Health Care Agent

My health care agent is specifically authorized to give consent for medical or surgical treatments when I cannot make my own decisions. My health care agent is authorized to carry out my wishes regarding life-sustaining treatments such as a feeding tube, CPR, breathing machine, and kidney dialysis. This includes consent to start, continue, or stop medical treatment.

Signature

I understand the importance and meaning of this document and my decisions. I understand that I can change my mind at any time. I revoke any prior Durable Power of Attorney for Health Care (DPOAH). I have filled out this document willingly. I am thinking clearly. The DPOAH reflects my health care agent choice(s). I want this DPOAH to become effective if I become disabled and a physician determines I do not have the capacity to make my own health care decisions. This DPOAH will continue as long as my incapacity lasts or until I revoke it, whichever happens first.

I understand that two witnesses or a notary must watch me sign this form and fill out their section.

My Signature: _____ Date: _____

My Name (printed): _____

Address: _____

City, State, ZIP: _____

Witnesses or Notary Requirement

Washington residents must have their signature on the Durable Power of Attorney for Health Care form **either** witnessed by two people **or** acknowledged by a notary public.

Please note: DPOAH witness requirements differ from the health care directive witness requirements.

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Name: _____

Date of Birth: _____

Durable Power of Attorney for Health Care – Naming a Health Care Agent

Option 1 – Two Witnesses

Rules for Witnesses:

- Must be at least 18 years of age and competent.
- Must watch you sign this form and complete their section of the form.
- Cannot be related to you or your health care agent by blood, marriage, or state registered domestic partnership.
- Cannot be your home care provider or a care provider at an adult family home or long-term care facility where you live.
- Cannot be your designated health care agent(s).

Witness Attestation: I declare I meet the rules for being a witness.

Witness #1

Signature: _____

Date: _____

Name (printed): _____

Address: _____

City, State, ZIP: _____

Witness #2

Signature: _____

Date: _____

Name (printed): _____

Address: _____

City, State, ZIP: _____

Option 2 – Notary

STATE OF WASHINGTON)
)
COUNTY OF _____)

This record was acknowledged before me on this _____ day of _____, _____

by _____.
(Name of individual)

_____
(Signature of notary public)

_____
(Title of office)

My commission expires: _____.

This ends the Durable Power of Attorney for Health Care.

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Name: _____

Date of Birth: _____

Advance Directive

Health Care Directive

What is a Health Care Directive?

A Health Care Directive is a legal document that tells your physician whether to stop life-sustaining treatments and allow a natural death if you have a terminal condition or are permanently unconscious and you cannot make medical decisions for yourself.

My Health Care Directive

This Health Care Directive is made this _____ day of _____(month/year).

I, _____, am able to make health care decisions. I deliberately and voluntarily declare the following. If I cannot make decisions for myself about the use of life-sustaining treatment, I want my health care agent, family and physicians to follow this directive. This is my final statement of my legal right to accept or refuse medical or surgical treatment. I accept the results of my decisions. If someone is appointed to make life-sustaining treatment decisions for me, I want that person to follow this directive and any other clear statements of my wishes.

Life-Sustaining Treatment

Life-sustaining treatment means a way to sustain, restore, or replace a vital function by different types of machines or devices, including artificial nutrition and hydration. For a patient with a permanent unconscious condition or terminal condition, life-sustaining treatment would only prolong the process of dying. Medicines or other treatments that are only used to ease pain *are not* considered life-sustaining treatments.

Terminal Condition

I understand that a terminal condition means a condition caused by an injury or sickness that a physician has judged cannot be cured or changed. The terminal condition would likely cause death within a short period of time. Life-sustaining treatment would only prolong my dying.

If my physician states in writing that I have a terminal condition and life-sustaining treatment would only prolong my dying, **(check one)**

- ☐ I DO want life-sustaining treatment.
- ☐ I DO NOT want life-sustaining treatment to be started. If it has been started, I want it to be stopped. I want to be allowed to die naturally.

Permanent Unconscious Condition

I understand that a permanent unconscious condition means an incurable and irreversible coma or a persistent vegetative state, and two physicians have judged there is little chance of recovery.

If two physicians state in writing that I am in a permanent unconscious condition, **(check one)**

- ☐ I DO want life-sustaining treatment.
- ☐ I DO NOT want life-sustaining treatment to be started. If it has been started, I want it to be stopped. I want to be allowed to die naturally.

Nutrition and Hydration

If I have a terminal condition or am in a permanent unconscious condition, I want my health care providers and health care agent to do the following **(check one for each)**:

Nutrition

- ◯ I DO want to have artificially provided nutrition.
- ◯ I DO NOT want to have artificially provided nutrition.

Hydration

- ◯ I DO want to have artificially provided hydration.
- ◯ I DO NOT want to have artificially provided hydration.

Pregnancy

If I am pregnant and my physician knows I am pregnant, I understand that this Health Care Directive will have no force or effect during my pregnancy.

Additional Directions

If I have a terminal condition or am in a permanent unconscious condition, I want my physicians, health care agent, or others to follow these additional directions about my health care treatment.

_____

_____

Signature

I understand the importance and meaning of this directive and my decisions. I am emotionally and mentally able to make the health care decisions in this directive. I understand that before I sign this directive, I can add to, delete from, or change the wording of this directive. I also understand that I may revoke and update this directive at any time. I want every part of this directive to be followed. If for any reason any part of my directive cannot be followed, I want the remainder of my directive to be followed.

I understand that two witnesses must watch me sign this form.

My Signature: _____

My Name (printed): _____

Address: _____

City/County/State/ZIP: _____

Witnesses or Notary Requirement

Washington residents must have their signature on the Health Care Directive form **either** witnessed by two people **or** acknowledged by a notary public.

Please note: The health care directive witness requirements differ from the DPOAH witness requirements.

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Name: _____

Date of Birth: _____

Health Care Directive

Option 1 – Two Witnesses

Rules for Witnesses:

- Must be at least 18 years of age and competent.
- Must watch you sign this form.
- Cannot be related to you by blood or marriage.
- Would not be entitled to any portion of your estate upon your death.
- Cannot be your attending physician or an employee of your attending physician or health care facility where you are a patient.
- Cannot be any person who has claim against any portion of your estate at the time of signature of this document.

Attestation: The declarer has been personally known to me or has provided proof of identity. I believe him or her to be capable of making health care decisions.

Witness #1

Signature: _____

Date: _____

Name (printed): _____

Address: _____

City, County, State, ZIP: _____

Witness #2

Signature: _____

Date: _____

Name (printed): _____

Address: _____

City, County, State, ZIP: _____

Option 2 – Notary

STATE OF WASHINGTON)
)
COUNTY OF _____)

This record was acknowledged before me on this _____ day of _____, _____

by _____.
(Name of individual)

_____
(Signature of notary public)

_____
(Title of office)

My commission expires: _____.

This ends the Health Care Directive.

Name: _____

Date of Birth: _____

Advance Directive

Share My Wishes

Once you complete the written documents, you should share your wishes and the documents with your health care agent, loved ones, physician, and hospital. If applicable, consider sharing them with your nursing home or assisted living facility. It is important that everyone has an updated copy.

Additional information on how to share your wishes is at **www.HonoringChoicesPNW.org**.

What if I change my mind about my wishes?

If your wishes change, tell your health care agent, loved ones, physician, hospital, and everyone who has a copy of your advance directive. You can revoke your Health Care Directive by destroying it; by writing to your physician that you want to revoke it (sign and date your communication); and/or by verbally telling your physician that you want to revoke it. Fill out a new advance directive with your current wishes. Give copies of the new form to your health care agent, loved ones, physician, and hospital.

My Durable Power of Attorney for Health Care and Health Care Directive are stored at:

Hospital: _____

Doctor's Office: _____

Health Care Agent: _____

Other: _____

Organ and Tissue Donation

If you want to be a donor, please tell your health care agent, family and health care providers.

☐ My organ and tissue donation wishes are stored at **www.lcnw.org.**

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Share My Wishes

Wallet Card

Carry the Wallet Card

- **Print** this page and fill in wallet card.
- **Cut** the card out with scissors following the dashed line.
- **Fold** the card in half.
- **Store** the folded wallet card in your wallet, billfold, purse, or pouch that you carry with you daily.

Complete the Wallet Card – Please print clearly.

- **My Name** – Print your legal first and last names and middle initial if you have one.
- **My Birthday** – Print your birthday including month, day, and year.
- **My Doctor** – Print the name of your primary health care provider.
- **Doctor's Phone #** – Print your provider's phone number with area code.
- **My Health Care Agent** – Print the first and last name of the person you identified on your DPOAH to make medical decisions for you if you cannot make them yourself.
- **Best Phone #** – Print the phone number with area code where your health care agent can most likely be reached.
- **My Advance Directive is on file at** – Print the location of your Advance Directive on the two lines. At a minimum, include the organization name and phone number. If space allows, please include the city and state.

ATTENTION HEALTH CARE PROVIDERS	Please Honor My Wishes
My Name _____ My Birthdate _____ My Doctor _____ Doctor's Phone # ( ) _____ Honoring Choices® PACIFIC NORTHWEST AN INITIATIVE OF Washington State Hospital Association / WSMA Foundation for Health Care Improvement	My Health Care Agent (identified on DPOAH) _____ Best Phone # ( ) _____ My Advance Directive is on file at _____ _____