# Advance Directive for Health Care (Living Will)

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A Health Care Directive (also called a Living Will) lets you state what kind of medical treatments you do or don't wish to have if you are terminally ill or permanently unconscious and cannot make decisions for yourself. It also lets you write down your health care values. (Form and instructions)

## 1. Fast facts

Form attached:
**Health Care Directive** (NJP Planning 510)

### What is a Health Care Directive?

It is a form that lets you state what kind of medical treatments you **do** or **don't** want if you are terminally ill or permanently unconscious and cannot make decisions for yourself. It also lets you write down your health care values.

## What are health care values?

They are your wishes and preferences for health care, including your religious, ethical, and personal preferences for care. They should guide health care decisions made for you when you cannot make decisions for yourself in **all** situations, not just if you are terminally ill or permanently unconscious.

Examples:

- "I'm worried about having the feeling of choking. Please do anything you can to relieve me of that stress."
- "I can tolerate a low level of pain – balance pain with keeping my brain clear."
- "Quality of life is more important to me than getting a lot of medical care."
- "What matters to me most is being in a hospital with excellent care."
- "The ability to be in the outdoors is what makes life worth living for me. If my health condition prevents me from being outside at all, then I would no longer want to live."
- "It is important to me to be able to recognize my family and say goodbye."
- "I want to spend my last days at home."
- "In my religion, we . . . (describe your religious traditions regarding health care).
- "I love jazz music and would like to listen to it whenever possible."

## Does my Health Care Directive form say who will make decisions for me?

No. You need a Durable Power of Attorney to do that. A power of attorney lets you choose a trusted friend or relative to help you with your health care decisions. You can fill it out separately (https://walawhelp.gavel.io/start/playground2/Durable%20Power%20of%20Attorney) or at the same time as your Health Care Directive (https://walawhelp.gavel.io/start/playground2/Health%20Care%20Directive) on WA Forms Online.

> Think carefully about who you want as your power of attorney (agent). Choose someone that you trust to make decisions in line with your health care values, even if they would make different decisions for themself.

## Can I still make my own decisions?

Yes! You can still make your own health care decisions if you are capable. You can also change or cancel your directive at any time.

## Does my Health Care Directive form need to be notarized?

It is best to sign your Health Care Directive form in front of a notary. If you can't find a notary, you can sign in front of two "disinterested" witnesses.

## What should I do after I sign it?

Give copies to your medical provider/s, your agent, and a trusted friend or relative. Ask your local hospital if they will put it on file for you.

## 2. Step-by-step

1. **Fill out your Health Care Directive form.** You can fill it out online (https://walawhelp.gavel.io/start/playground2/Health%20Care%20Directive) or by hand.

2. **Sign in front of a notary and/or two witnesses.**

3. **Where to keep your directive:** Unlike most legal documents, copies of directives are just as valid as the original. Keep the original signed documents in a secure but accessible place. Your directives are useless if they can't be found.

   ***Tip!*** Ask your health care decision-maker to keep a digital copy of your signed directives on their smartphone for easy access in the event of a medical emergency. You may also ask them to keep a copy in the glove box of their car, if they have one, and in their suitcase.

4. **Who should have a copy?** Make copies of your Health Care Directive and share it with people involved in your care. This may include your health care decision-maker, doctors, lawyer, family, close friends, clergy, and any facility that might be involved in your care.

   If you can, attach a copy of your Power of Attorney or other legal document naming a health care decision-maker to your Health Care Directive. Make sure there is a copy of your directives on file at your local

hospital and your long-term care or memory care facility. If your state has an advance directive registry online, post your directive there.

5. **Tell important people about your wishes.** It is extremely important for you to tell your health care decision-maker and anyone else who may be involved in making decisions related to your Health Care Directive what your wishes are and why you are making those decisions. Repeat these conversations periodically, especially if your medical condition changes.

   > Although not required to complete this directive, we highly recommended you name a health care decision-maker whom you trust to honor your wishes.

   Make clear to your close friends and relatives that your health care decision-maker will have final authority to act on your behalf. Emphasize that you don't want them to disregard or undermine your wishes because they think your quality of life is acceptable or because you appear to be happy or comfortable. If your health care decision-maker is not supportive or disagrees with the decisions you make in your directive, you should appoint someone else as your health care decision-maker.

6. **If you are admitted to a health care or long-term care facility or enrolled in a home-based health care or hospice program:** Give admissions staff a copy of your completed Health Care Directive and any other directives. Also tell your health care decision-maker to give admissions staff a copy if you are admitted *after* you lose capacity.

7. **Keep your directives updated.** Be sure to occasionally review your Health Care Directive and other directives to be sure they reflect your current preferences and values. Initial and date it whenever you review it.

   ***Tip!*** Create a calendar reminder to review your directives every 1-2 years.

8. **Canceling (revoking) your directive:** If you revoke a directive, make sure you notify your health care decision-maker, family, and doctors. If possible, retrieve and destroy copies of your revoked directive, or tell those who have revoked copies to destroy them. Keep one copy of your revoked advance directive in your records with the word "REVOKED" written across the front. This could help if someone needs to rely on a new directive. The most recently dated directive will be honored over any older directive.

## 3. Glossary

Here are some terms you may find helpful when reading a health care directive:

- **Artificial nutrition:** a way to feed you if you can't feed yourself or swallow. A feeding tube is inserted through your nose and down to your stomach. If you need tube feeding for an extended period, a feeding tube may be surgically inserted directly into your stomach. Artificial nutrition can be harmful if you are dying and your body cannot use the

nutrition properly.

- **Artificial hydration:** a way to hydrate you if you can't drink. A plastic IV tube is inserted into the vein to deliver hydration. Artificial hydration can be harmful if you are dying and your body cannot use the hydration properly.
- **Artificial respiration (ventilator):** a machine that helps you breathe. A tube connected to the ventilator is put down your throat into your trachea (windpipe) so the machine can force air into your lungs. Because the tube is uncomfortable, medicines are often used to keep you sedated while on a ventilator. If you need to remain on a ventilator for a long time, a doctor may perform a tracheotomy where a tube is inserted directly into your trachea through a hole in your neck.
- **Blood dialysis or filtration:** a procedure to remove waste products and excess fluid from the blood when your kidneys stop working properly. Tubes are inserted into your arm to allow your blood to pass into an external machine where it is filtered before it passes back into your arm along another tube.
- **Blood transfusion:** a procedure where a tube is inserted into your arm and whole blood, or parts of blood, are put into your vein to replace lost blood.
- **Cardiopulmonary Resuscitation (CPR):** a treatment that is initiated when someone has a complete cardiac arrest, no heartbeat and not breathing. CPR involves repeatedly pushing on the chest with force, while putting air into the lungs. The force has to be quite strong, and sometimes ribs are broken or a lung collapses. Electric shocks, known as defibrillation, and medicines might also be used. A person may also be intubated in this process, which is a tube put down the throat and into the windpipe to help get air into the person quickly.

- **Life-sustaining treatment:** any mechanical or artificial medical intervention that, when applied to a person diagnosed with a terminal condition or a person in a permanent unconscious condition, would only prolong the process of dying. Life-sustaining treatment does not include medication or medical intervention necessary to alleviate pain only.
- **Palliative care**: Specialized medical care for people living with a serious illness. It is focused on providing relief from the symptoms and stress of the illness. The goal is to improve quality of life for both the patient and their close friends and family.
- **Permanent unconscious condition:** an incurable and irreversible condition; a condition where a person has no reasonable probability of recovery from an irreversible coma or a persistent vegetative state according to reasonable medical judgment.
- **Terminal condition:** an incurable and irreversible condition caused by injury, disease, or illness, that will cause death within a reasonable period of time according to accepted medical standards, and where the application of life-sustaining treatment serves only to prolong the process of dying.

# Health Care Directive

My name is _____. My date of birth is _____.

I am a person with decision-making capacity. I voluntarily sign this directive. If I cannot make decisions for myself, my relatives, friends, agents, and medical providers should fully honor every part of this directive. If any part of this directive is invalid, the rest should be honored. I revoke any health care directives I have signed in the past.

1. **Health Care Values:** The following wishes and preferences should guide all decisions made about my care:

    a. **What makes my life worth living.**

    [ ] Some terminal or serious conditions may stop me from **ever** doing the things that make life worth living for me. In that situation, I want you to stop all treatment except comfort care, pain relief and palliative care if I **cannot ever again**:

    [ ] Recognize my close friends and family in any meaningful way

    [ ] Exercise

    [ ] Be outdoors

    [ ] Read

    [ ] Watch tv shows/movies

    [ ] Do the following: _____

    [ ] Other: _____

    _____

    _____

    [ ] Life is always worth living. Do everything you can to keep me alive.

    b. **My hopes**. In my last days, I hope to spend my time:

    [ ] With my close friends and family: _____

    _____

    [ ] With the following comfort items and/or pets: _____

    _____

    [ ] Eating/drinking the following items, if possible: _____

    _____

    [ ] Listening to the following music: _____

    _____

    [ ] Other: _____

    _____

**c. Pain Management.** Medications used to treat pain often come with the side effect of drowsiness and decreased mental clarity. In my last days, I hope to balance pain management and mental clarity in this way:

[ ] I hope to spend my time in as little pain as possible, even if I'm not mentally clear.

[ ] I am willing to tolerate the following level of pain in the hopes of having more mental clarity:

[ ] 1 = Pain I hardly notice

[ ] 2 = Pain I notice but does not interfere with activities

[ ] 3 = Pain that sometimes distracts me

[ ] 4 = Pain that distracts me, but I can do usual activities

[ ] 5 = Pain interrupts some activities

[ ] 6 = Pain is hard to ignore, I avoid usual activities

[ ] 7 = Pain is my focus of attention, prevents daily activities

[ ] 8 = Pain is awful, it's hard to do anything

[ ] 9 = Pain is unbearable, I'm unable to do anything

[ ] 10 = Pain as severe as I can imagine. Maximum mental clarity is the most important.

**d. My fears.** There are situations or treatments I am concerned about and want to prevent or avoid if possible.

[ ] I have a fear of (*examples:* shortness of breath, thirst, choking sensation, nausea, headaches) _____. Please do everything possible to relieve me of that feeling through comfort care.

[ ] I don't want to spend our life savings on my final illness. Please provide the least costly comfort care for my end-of-life care.

[ ] Other: _____

_____

**e. Where I want to be**. I would like to receive care in the following place/s if possible:

[ ] My home

[ ] Hospice care

[ ] An assisted living facility

[ ] An adult family home

[ ] A nursing home

[ ] A hospital

[ ] I know that it may not be possible for me to receive care where I want, given my needs and circumstances at the time. I trust my healthcare decision-maker/s and

know that they will make the best decisions for me after considering my values, and consulting with my loved ones and care providers.

[ ] Other: _____

_____

**f. Other things to know about me**:

[ ] I would like my friends and family to be notified of my condition and given an opportunity to visit me to say goodbye.

[ ] I would like to be kept alive for a short period of time if needed to allow friends and family time to travel and say goodbye.

[ ] If possible, I would like to be able to look out a window or see nature during my last days.

[ ] My religious or cultural traditions require the following practices around health care and end of life care:

_____

_____

[ ] Other: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

**2. Terminal Illness or Permanent Unconscious Condition.** If my attending physician diagnoses me with a terminal condition or two physicians determine that I am in a permanent unconscious condition, and if my physician/s determine that life-sustaining treatment would only artificially prolong the process of dying, I want:

**a. Comfort Care and Pain Medication** (*check one*)

[ ] If I appear to be experiencing pain or discomfort, I want treatment and medications to make me comfortable, even if my medical providers believe it might unintentionally hasten my death.

[ ] I **don't** want treatment and medications to make me comfortable if those treatments and medications might hasten my death. Do everything possible to keep me alive even if I am in pain. Please use pain management methods that will not hasten my death.

**b. Artificial Life Support** (*check one*)

[ ] Please use all treatment options to artificially prolong the process of dying or sustain me in a permanent unconscious condition.

[ ] The following treatment should be **withheld** or **withdrawn** from me after (*period of time*) _____ (*check all that apply*):

[ ] Artificial nutrition

[ ] Artificial hydration

[ ] Artificial respiration (ventilator)

[ ] Cardiopulmonary Resuscitation (CPR), including artificial ventilation, heart regulating drugs, diuretics, stimulants, or any other treatment for heart failure

[ ] Surgery to prolong my life or keep me alive

[ ] Blood dialysis or filtration for lost kidney function

[ ] Blood transfusion to replace lost or contaminated blood

[ ] Medication used to prolong life, not for controlling pain

[ ] Any other medical treatment used to prolong my life or keep me alive artificially

**3. After Death**

**a. Organs, body parts, and tissues**

[ ] I want to donate organs, body parts, and tissues.

(*Specific instructions, if any*): _____

_____

[ ] I **don't** want to donate organs, body parts, and tissues

**b. Medical education or research**

[ ] I consent to use all or part of my body for medical education or research.

[ ] I **don't** consent to use all or part of my body for medical education or research.

**c. Autopsy**

[ ] I consent to an autopsy.

[ ] I **don't** consent to an autopsy.

**d. Releasing my body and remains**

[ ] Upon my death, my body and remains can be released to the following person/s:

(*Name/s and contact information*): _____

_____

**4. Health Care Institutions.** If I am admitted to a hospital or other medical institution that will not honor this directive due to religious or other beliefs: (1) my consent to admission is not implied consent to treatment, and (2) I want to be transferred as soon as possible to a hospital or other medical institution that will honor my directive.

**5. Changes and Cancellation.** I understand that I can change the wording of this directive before I sign it. I also understand that I can cancel this directive at any time.

▶ _____ _____

My signature (*in front of a notary or witnesses*) Date

## Notarization (preferred)

State of Washington

County of _____

Signed or attested before me on (*date*) _____

by (*name*) _____.

▶ _____

Signature of Notary

Notary Public for the State of Washington.

My commission expires _____.

## Statement of Witnesses (only if you cannot find a notary)

On (*date*): _____, (*name*): _____ signed this Health Care Directive in my presence. This person is personally known to me or provided proof of identity. I believe this person is capable of making health care decisions.

- I am not related to this person by blood or marriage.
- I am not eligible to inherit money or property from this person.
- I do not have a legal claim against this person.
- I am not this person's attending physician. I am not an employee of their physician, or of any health facility where they are a patient.

**Witness 1**

▶ _____

Signature

Print Name: _____

Address: _____

_____

Phone: _____

**Witness 2**

▶ _____

Signature

Print Name: _____

Address: _____

_____

Phone: _____

**Health Care Directive**
**Attachment: Contact Info**

## My information

My name _____

My date of birth _____

My phone number _____

My email address _____

My mailing address _____

_____

My primary care medical provider

_____

## Power of attorney

[ ] I have a **Durable Power of Attorney** that lets someone else (my "agent") make health care decisions for me if I am not able.

## My health care agent (if any)

Name _____

Relationship to me (Examples: friend, partner, spouse, sister, etc.)

_____

Phone _____

Email _____

## My alternate health care agent (if any)

Name _____

Relationship to me (friend, partner, spouse, sister, etc.)

_____

Phone _____

Email _____

## My 2nd alternate health care agent (if any)

Name _____

Relationship to me (friend, partner, spouse, sister, etc.)

_____

Phone _____

Email _____

## Other advance planning

I have the following other documents about advance planning or end-of-life (*list document/s*):