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*):