



Dear Advance Planner,

Thank you for downloading Compassion & Choices of Washington's (C&C) Advance Directive packet. The C&C Advance Directive set the standard in Washington State for advance planning documents. It has been widely praised by health care professionals and advocates, and is endorsed by Senior Services of Seattle/King County. The instruction packet includes information pertinent to Washington State registered domestic partners. The C&C Advance Directive:

- Combines your Health Care Directive and Durable Power of Attorney for Health Care into one document.
- Applies if you have a terminal or non-terminal medical condition.
- Contains no anti-choice statements.
- Includes an Alzheimer's and dementia provision.
- Uses very specific terminology regarding when you don't want life-sustaining treatment and what treatments you don't want.
- Allows you to place limits on how long you would remain in a coma or persistent vegetative state.
- Offers an option of no life-sustaining treatment under any circumstances (for the very elderly, for instance).
- Includes a statement requesting maximum pain and comfort care, even if it might hasten your dying process.
- Remains in effect after death (for organ donation, disposition of remains, etc.).
- Includes a provision stating that if a guardian is appointed for you, that guardian should be the health care agent you named.
- Affirms a health care agent's right to complete a Physician Orders for Life-Sustaining Treatment (POLST) form on behalf of the maker.
- Allows consideration of every legal, ethical option.

If you have questions or need guidance in preparing your new C&C Advance Directive, please call our office at 206-256-1636 or 1-877-222-2816 toll-free, and a staff member will be glad to assist you. Thank you for being proactive about your end-of-life choices!

Warm regards,

Robb Miller  
Executive Director



## PLEASE CONSIDER A TAX DEDUCTIBLE GIFT TO COMPASSION & CHOICES OF WASHINGTON

Compassion & Choices of Washington is a small nonprofit organization that depends on the generosity of individual donors like you. Our new advance directive packet is provided to free to anyone who requests it. However, donations are always gratefully accepted, and a minimum suggested donation of \$5 for this packet would be deeply appreciated. If you have limited means, no donation is necessary. All donations are tax deductible.

✂ -----

I would like to support Compassion & Choices of Washington.

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I \_\_\_\_\_ authorize C&C of Washington to charge the  
*(signature of cardholder)* total amount below to my credit card.

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Fax to: 206.256.1640, or

Mail to: Compassion & Choices of Washington, PO Box 61369, Seattle WA 98141  
For more information, call Compassion & Choices of Washington at 206.256.1636 or 1.877.222.2816 toll-free.

All donations are tax deductible. All records are confidential.

Thank you for your supporting choice at the end of life!



## ABOUT ADVANCE DIRECTIVES

Advance directive is a general term for oral or written instructions about future medical care if a person becomes incapable of stating his or her wishes. In these documents, both wanted and unwanted treatment may be specified. In Washington, there are three types of advance directives: the Health Care Directive, the Durable Power of Attorney for Health Care, and the Physician Orders for Life-Sustaining Treatment.

Remember, advance directives are only part of the process. Protecting your health care choices is a three-step process: *deciding* what you want; *communicating* your intentions so that others understand them; and *committing* your providers, family, and health care agent(s) to the acceptance (and sometimes defense) of your choices.

A **Health Care Directive** (also known as a living will, directive to physician, or physician directive) is a legal statement to all your health care providers that describes your general wishes or desires for end-of-life care. In particular, Health Care Directives speak to the question of whether and how you want to be kept alive by medical treatment if you are unable to make decisions. Your Health Care Directive should specifically state the life-sustaining treatments you do or do not want. These should include resuscitation, use of an artificial ventilator, and artificial nutrition and hydration. It should be in all your medical records.

When you present your Health Care Directive to your physician, ask if he or she will honor it. If not, find a physician who will. Most states do not require a specific form or format. In Washington, the basic form available covers only terminal illness, and COMPASSION & CHOICES of Washington (C&C) considers it too limited. In order to make a Health Care Directive legally binding, you must sign the document in the presence of two qualified, adult witnesses. *A Health Care Directive can prevent immense family conflict about your wishes for treatment if you become unconscious or unable to make medical decisions.*

A **Durable Power of Attorney for Health Care** (DPAHC) is the legal means by which you designate someone (referred to as your health care agent, surrogate decision maker, health care proxy, or attorney in fact) to make health care decisions if for any reason you should lose the capacity to do so. In the event that your primary agent is unable to make decisions on your behalf, you may also name an alternate agent. Anyone over the age of 18 may make a DPAHC, provided he or she is competent. Additionally, any individual over 18 can act as an agent or alternate agent provided he or she is of sound mind and meets certain qualifications.

A DPAHC is limited to health care decisions and does not affect a power of attorney you may have for financial or other matters. Washington State law does not specifically require witnessing or notarizing your DPAHC. *A DPAHC stands up legally, particularly when the agent's decisions are consistent with directives contained in the patient's Health Care Directive.*

Once the DPAHC is in place, you continue to make your own care decisions for as long as you are able. It is only when you cannot make your wishes known that your health care agent can act. When you are again able to make your own decisions, your agent loses power to make decisions for you. It is very important to pick someone you trust and who knows your wishes. It is also important to choose an individual you feel can be assertive in the event that caregivers or family members challenge your wishes.

**Communicate:** Let your agent know exactly what kind of care you wish to have, and what types of treatment you do and do not wish to have. Make clear to other family members that your health care agent(s) will have final authority to act on your behalf. If you feel that certain family members will not honor your wishes, you may include a statement directing physicians and the courts to disregard his or her demands and to follow only the directives of your agent(s). For the sake of all concerned, be sure to *discuss your intentions face-to-face*.

A **Physician Orders for Life-Sustaining Treatment (POLST)** form (formerly called the EMS - No CPR form) is intended for any adult, 18 years of age or older, with serious health conditions. You (or your health care agent) and your physician may use POLST to write clear and specific medical orders that indicate what types of life-sustaining treatment you want or do not want at the end of life. *Both the maker and a physician must*

*sign the bright green form in order for it to be honored by other health care professionals.* No witnessing or notarizing is required. Emergency Medical Services (EMS) personnel are required to honor POLST, and it remains with you if you are transported between care settings. The POLST form is relatively new in Washington, and many physicians are still unaware of it. If your physician does not have POLST forms available, ask her or him to contact the Washington State Medical Association (see contact information below), or contact our office and request one. Properly completed, the POLST form is probably the most effective advance directive because your wishes are expressed as medical orders.

### **Other Considerations**

After you complete your advance directives, send or give copies to your physician(s), lawyer, agent(s), family members, and other loved ones who should know about your wishes.

Health Care Directives have limitations. They are part of the health care planning process and should be best thought of as "living wishes." In the real world of medical decision-making, fear of liability can keep providers from acting on patients' intentions.

One of the best uses for a Health Care Directive is as a guide to the DPAHC agent. When the health care agent(s) acts within the general scope of the Health Care Directive, he or she is on solid legal ground. If there is no Health Care Directive, or the agent's actions are not consistent with the Health Care Directive, the health care agent may be challenged. For these reasons, you should have both a DPAHC and a Health Care Directive.

Review your Health Care Directive and DPAHC occasionally to be sure they reflect your current preferences and values. To affirm that they reflect your current wishes, initial and date the documents whenever you review them.

C&C recommends that advance directives be signed and witnessed in the presence of a notary because it eliminates any doubt about the validity of your documents. Additionally, if you travel out of state, some states do require notarization.

### **These forms are available from:**

- Your attorney or physician.
- COMPASSION & CHOICES of Washington – 206.256.1636 or 877.222.2816 (toll free), [info@CandCofWA.org](mailto:info@CandCofWA.org) or [www.CandCofWA.org](http://www.CandCofWA.org). C&C has a new, comprehensive combination Health Care Directive and DPAHC. We also have POLST forms available and a system called the *Wonderfile* for organizing your end-of-life documents.
- National Hospice and Palliative Care Organization, [www.nhpco.org](http://www.nhpco.org), provides basic advance directives online for each state. Click on "Advance Directives."
- Washington State Medical Association – 206.441.9762 or 800.552.0612 provides basic advance directives. They provide POLST forms only to physicians and other medical providers.

### **If you have questions or need additional information, please contact:**

COMPASSION & CHOICES OF WASHINGTON  
PO Box 61369 Seattle WA 98141  
206.256.1636 PHONE 1.877.222.2816 TOLL FREE 206.256.1640 FAX  
internet: [www.CandCofWA.org](http://www.CandCofWA.org) email: [info@CandCofWA.org](mailto:info@CandCofWA.org)



## INSTRUCTIONS FOR PREPARING YOUR COMPASSION & CHOICES OF WASHINGTON ADVANCE DIRECTIVE

The Compassion & Choices (C&C) Advance Directive combines two legal documents, the Durable Power of Attorney for Health Care (DPAHC) and the Healthcare Directive. These combined documents protect your right to refuse treatment you do not want or to request treatment you do want, in the event you lose the ability to make decisions.

The C&C Advance Directive was created to comply with Washington State law. It may not be honored in all states. For more information about the DPAHC and the Health Care Directive, see our *About Advance Directives* information sheet (enclosed).

- Read the instructions in their entirety before completing your advance directive.
- Photocopy the advance directive before you start so you have an original if you need to start over.
- Talk with your family, friends, and physicians about your decision to complete an advance directive. Be sure the person you appoint as your health care agent understands your wishes and agrees to honor them.

Refer to the instructions in the gray sidebar; they indicate where you need to initial, insert your personal instructions, or sign the form. The gray sidebar instructions provide the basic information you need to complete this document, however there are a few sections that require some additional information and/or exploration.

The numbers below correspond to the same sections on your C&C Advance Directive form.

### 1. WHEN I WANT THIS DOCUMENT TO APPLY (page 1)

Washington law does not explicitly allow health care directives to remain in effect after death. This section states your intention that the document remain in effect to carry out any procedure you request or consent to in section 9.

### 2. MY HEALTH CARE AGENT (page 1)

The person you name to be your health care agent:

- Must be at least 18 years old and mentally competent.
- May be a family member or close friend whom you trust to make serious decisions.
- Should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you.
- Should be someone who you feel can be assertive in the event that caregivers or family members challenge your wishes.
- Does not have to be your spouse, partner, or a member of your biological family.
- Need not live in Washington but would need to be readily available in a medical emergency.

The person you appoint as your health care agent cannot be:

- Your doctor or an employee of your doctor.
- An owner, operator, administrator, or employee of a health care facility in which you are a patient at the time you sign your advance directive.

However, if one of the individuals listed above is also your spouse, adult child, brother or sister, you may appoint that individual to be your health care agent. In the event that your agent is unable to make decisions on your behalf, you may also name an alternate agent to make decisions.

Naming a DPAHC is highly recommended. If you do not designate a health care agent, the law authorizes the following people, in order of priority, to make health care decisions for you. (When there is more than one person, such as your children, parents, or brothers and sisters, all must agree.)

- A guardian with health decision-making authority, if one has been appointed.
- Your spouse or Washington State registered domestic partner.
- Your adult children.
- Your parents.
- Your adult brothers and sisters.

Note to lesbian, gay, bisexual, transgender, or queer (LGBTQ) individuals: If you do not designate your partner as your health care agent and you are not registered as domestic partners in Washington, your partner or spouse (if you were married in another state or country) has no legal right to make your health care decisions in Washington. For more information about LGBTQ issues, please request our *LGBTQ End-of-Life Advice & Hospital Visitation Authorization* brochure.

### 3. THE AUTHORITY I GIVE MY AGENT (page 2)

This section refers to the Physician Orders for Life-Sustaining Treatment (POLST) form, a relatively new advance directive in Washington requiring a physician's signature to be valid. The POLST form is intended for any adult, 18 years of age or older, with serious health conditions. The form translates your wishes regarding life-sustaining treatments into a physician's orders. While the POLST program specifically permits your health care agent to fill out a POLST form for you, some physicians may be reluctant to sign when someone other than the patient is requesting it. Granting specific authority to your health care agent to complete a POLST form on your behalf may alleviate a physician's concern. For more information about POLST, see our *About Advance Directives* information sheet (enclosed).

### 4. HOW TO MAKE HEALTH CARE DECISIONS FOR ME (page 2)

This section is especially important when no health care agent is named in section 2 (not recommended). For those who do name a health care agent, it provides guidance if a situation not covered by the C&C Advance Directive should occur.

### 5. WHY I AM MAKING THIS DOCUMENT (page 2)

This section allows you to attach an additional statement that describes and reinforces values expressed in your document. You may want to write in more specific terms what you want your dying to be like. This statement might include relevant medical history involving you or close family and friends and deeply held religious, spiritual, and philosophical beliefs. If you feel that certain family members will not honor your wishes or challenge decisions by your health care agent(s), you may include information here directing physicians and the courts to disregard his or her demands. However, no additional statement to section 5 is necessary or required.

### 6. WHEN I DO NOT WANT LIFE-SUSTAINING TREATMENTS (page 2)

(a) *I have lived a long life, and I am ready to accept death when it comes . . .*

Some very old people or people with incurable illnesses such as Alzheimer's disease thoughtfully and freely express the wish to forgo any life-sustaining treatment. If you are a younger adult who wants to refuse all forms of life-sustaining treatment because your current medical condition(s) is causing you to experience an unacceptable quality of life, be sure to explain this in the attachment to section 5.

IMPORTANT: If you initial this section, cross out sections 6(b) and 6(c), and go to section 7.

(b) *These are the qualities of life I consider worse than death . . .*

(1) *Unconsciousness or coma from which the ability to think and communicate . . .*

Heart attack, stroke, head injury, and drug overdose can all result in unconsciousness that may later be diagnosed as chronic coma or persistent vegetative state (PVS). A majority of comatose adults who do not show clear signs of recovery within a few weeks (usually between two and four) are unlikely to recover; most will either die or enter a PVS.

This provision is included to help avoid a situation in which life-sustaining treatment during coma or PVS is continued indefinitely because a physician remains uncertain of the prognosis. In light of your own values, you may want to limit the length of time life-sustaining treatment would be used in such a circumstance. If you prefer to rely on a physician's judgment, place a dash ( — ) in the "insert number" space.

(6) *Other circumstances in which I would not want life-sustaining treatment . . .*

Your experience may enable you to identify circumstances, in addition to or instead of those in (b)1 through (b)5 that would mean an unacceptable quality of life for you. You may use this space to state, in your own words, any outcomes or conditions you consider "worse than death." People with potentially life-threatening, chronic conditions are encouraged to discuss with their physicians any specific instructions relating to their conditions that they want to include here.

(c) TEMPORARY USE OF LIFE SUSTAINING TREATMENT (page 3)

Sometimes it is hard for physicians to know if using life-sustaining treatment for a short period of time will enable a patient to recover. Some people want their physician to try such treatments if there is a good chance of recovery. Others would not want life-sustaining treatment begun because they fear once treatment has started it might be difficult to get it stopped.

If you want temporary use of life-sustaining treatment when your physician believes it would restore an acceptable quality of life, you can place an approximate time limit on such attempts. It can be very difficult for physicians and health care agents to give up trying when they know it means a patient will soon die; stating a time limit will give them permission to stop treatment when there is no reasonable expectation of recovery. If you prefer to rely on a physician's judgment, place a dash ( — ) in the "insert number" space.

This time limit for temporary treatment is not the same as the time limit you may include in (b)1 above. In (b)1 the issue is uncertainty whether an unconscious patient will regain consciousness. This section applies only to situations where a physician believes that life-sustaining treatment for a short period will restore acceptable quality of life.

## 7. LIFE-SUSTAINING TREATMENTS I DO NOT WANT (page 3)

Physicians may be reluctant to forgo life-sustaining treatment they believe will keep a patient alive, unless they know a patient has indicated his or her wishes. This section identifies life-sustaining procedures you would not want started or continued.

Initial any treatments you do not want. Treatments that you do not initial might be used, but this does not mean they will be used. Patients or their families have no legal right to require treatments that, according to their physicians, are of no medical value to the patient.

## 8. MY WISHES CONCERNING COMFORT CARE . . . (page 4)

This section has been added because health care providers often manage pain poorly. The administration of high levels of pain medication can decrease breathing to the point of hastening death. Decreased breathing in such circumstances does not cause suffering because the medication produces heavy sedation. Drug dependency in a dying person (whose condition warrants high levels of medication to control pain) is neither an ethical or legal concern. Developing a tolerance to pain medication is not addiction.

## 9. MY WISHES CONCERNING OTHER MATTERS (page 4)

(a) *I consent to medical treatments that are experimental.*

A physician might offer a new test or procedure that could be beneficial, even though its effectiveness or risks are not well known.

(b) *I want to donate organs/tissues.*

Your wish to be an organ donor can also be indicated on your driver's license and/or by completing an organ donor card. Because Washington law does not explicitly give health care agents priority in consenting to organ or tissues donation, it is important that everyone in your immediate family knows about and supports your wishes.

(c) *I consent to autopsy.*

After death, physicians sometimes want to do autopsies to obtain information about an injury or disease process that could help them treat other patients effectively. If you are considering the option of hastening death with medication, you should not consent to autopsy.

(d) *I consent to use of all or part of my body for medical education or research.*

If you wish your body to go to a specific medical or research institution, you should make prior arrangements with that institution and with your physician (in addition to initialing "YES").

(e) *I want my remains to be disposed of as follows:*

Often people have particular ideas about what they want (or do not want) done with their bodies after death. You must still make the necessary arrangements so that your instructions can be carried out. If you have left instructions in a property will or have made arrangements with a funeral home or People's Memorial Association, there is no need to complete this part. If you do not use this section, cross it out.

## 10. IF A COURT APPOINTS A GUARDIAN (page 4)

Unlike many states, Washington law does not direct that a health care agent should be the court's first choice for guardian. It makes sense to request that one of your health care agents serve as your guardian if such an appointment becomes necessary, because that is the person you trust who could make a decision to end your life. A judge is not required to appoint the person you request, but the court would probably give your wishes serious consideration.

## 11. HOW THIS DIRECTIVE CAN BE REVOKED OR CANCELED (page 4)

You may revoke your C&C Advance Directive at any time by:

- Canceling, defacing, obliterating, burning, tearing, or otherwise physically destroying it or having another destroy it for you in your presence.

- Executing a written and dated revocation.
- Orally expressing your intent to revoke it.

If you do revoke your advance directive, you should notify your health care agent and your health care provider(s) in writing of your intent to revoke. If you are unable to write, you can have someone else write a statement for you explaining that you are unable to write, but want your advance directive revoked.

While Washington law does not permit an incompetent person to execute an advance directive, this is not true for revocation. Incapacity to make decisions sometimes cannot be clearly determined for a very ill patient who can still communicate; this makes it hard to decide if a statement revoking an advance directive is an authentic expression of intent. Therefore, the law allows an incompetent person to revoke his or her advance directive. This section clarifies that statements or actions by you expressing disagreement with a particular decision made by your health care agent does not constitute revocation.

## 12. SUMMARY AND SIGNATURE (page 4)

Do not sign and date your form until you are in the presence of valid witnesses and a notary.

## 13. STATEMENT OF WITNESSES (page 5)

In order to make your advance directive legally binding, you must sign the document in the presence of two adult witnesses. The two witnesses cannot be:

- Related to you by blood or marriage.
- Entitled to any portion of your estate through the operation of law or through any will or codicil.
- A person who has a claim against your estate.
- Your attending physician or an employee of your attending physician.
- An owner, operator, administrator, or employee of a health care facility in which you are a patient at the time you sign your advance directive.

Make sure your witnesses meet the criteria for being a witness. Notaries do not normally affirm anything beyond the identity of the person signing the document before them. While Washington State does not explicitly require notarization of this advance directive to make it legal, this form includes a notary statement because we believe that notarization eliminates doubt about the validity of your document in the future. Additionally, some states do require advance directives to be notarized.

## AFTER COMPLETING YOUR ADVANCE DIRECTIVE

1. **Where to keep your Advance Directive:** Your advance directive is an important legal document. Keep the original signed documents in a secure but accessible place. Do not give the original documents to your attorney or put them in a safe deposit box or any other security box that would keep others from having access to them in the event of an emergency. Your health care agent(s) or other close family and friends should know exactly where to look for your document.
2. **Who should have a copy:** Give photocopies of the signed originals to your health care agent(s), doctor(s), lawyer, family, close friends, clergy, and anyone else who might become involved in your health care. If you enter a nursing home or hospital, have photocopies of your documents placed in your medical records. Originals and copies of your advance directive are equally valid.

3. **Tell important people about your wishes:** The importance of discussing your documents with the important people involved cannot be overemphasized. Discuss your wishes concerning medical treatment with your health care agent(s), doctor(s), clergy, and family and friends often, particularly if your medical condition changes. Make clear to other family members that your health care agent(s) will have final authority to act on your behalf. For more advice about communicating your end-of-life wishes, see our *Talking To Your Family About Dying* information sheet (enclosed).
4. **Will the doctor honor your wishes?** When you present your advance directive to your physician, ask if he or she will honor it. If not, find a physician who will. See enclosed information sheet, *Talking to Your Doctor*.
5. **If you are admitted to a healthcare facility or enrolled in a home-based healthcare program:** You may be offered other living will forms. Do not fill out such forms; give admissions staff a copy of your completed C&C Advance Directive. Most other forms are not as comprehensive as C&C's Advance Directive.
6. **Making changes:** If you want to make changes to your documents after they have been signed and witnessed, you should complete a new document. However, updating addresses or phone numbers is permissible.
7. **Keep your advance directive updated:** Be sure to review your advance directive occasionally to be sure it reflects your current preferences and values. Initial and date it whenever you review it.
8. **Revoking your Advance Directive:** If you revoke your advance directive as per section 11, make sure you notify your health care agent(s), your family, and your doctor(s). If possible, retrieve and destroy copies of your revoked document, or instruct 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 shows how long you have thought about these issues and could help if it becomes necessary to rely on a new advance directive shortly after you prepared the document.
9. **POLST form:** Be aware that your advance directive will not be effective in the event of a medical emergency. Ambulance personnel are required to provide cardiopulmonary resuscitation (CPR) and other life-sustaining treatments unless a valid Physician Orders for Life-Sustaining Treatment (POLST) form is present. For more information about POLST, see the POLST section of our website: [www.CandCofWA.org/polst.html](http://www.CandCofWA.org/polst.html)
10. **Travel to other states:** If you travel, you may want to take copies of your advance directive with you, as other states may honor it. Although they may have specific requirements about notarization or witnessing, most states do not require a specific form or format.
11. **Online Registry:** Register your advance directive with the Washington State Living Will Registry by following instructions found at [www.doh.wa.gov/livingwill](http://www.doh.wa.gov/livingwill). The registry is managed by the Washington State Department of Health and allows your advance directive to be accessed by your medical providers anywhere via internet access. Those who register will receive a wallet card and a sticker to place on their driver's license. Note: Although the state provides living will documents on this site, we recommend sending our advance directive document because the state documents lack key provisions.

If you have questions or need guidance in preparing your C&C Advance Directive, please call our office at 206.256.1636 or 1.877.222.2816 toll-free, and a staff member will be glad to assist you.



**INSTRUCTIONS**

**Print your name on this line.**

**Read this entire document before filling it out.**

**This is your document. When you have completed it, it should express your choices.**

**Throughout this document, initial your choice.**

**Put a dash ( — ) in any space you do not initial.**

**Designating someone to make health care decisions for you is highly recommended.**

**If you do not name an agent, cross out sections 2 and 3, and go to section 4.**

**For information about who can or cannot be your agent, see section 2 in the Instructions.**

**DURABLE POWER OF ATTORNEY FOR HEALTH CARE and HEALTH CARE DIRECTIVE of:**

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This document states my choices about use of life-sustaining medical treatment and comfort care. It is meant to inform and guide whoever will make health care decisions for me, if I become unable to communicate myself.

**1. WHEN I WANT THIS DOCUMENT TO APPLY**

I want this document to apply if I become unable to make my own health care decisions.

I understand that such inability may only be temporary, and if I become unable to make certain decisions, I may still be able to make others. When I can make my own health care decisions I want to do so.

Even when I cannot make my own health care decisions, I want my physician and my health care decision maker(s) to talk to me honestly about my condition and treatment, if they think I might understand.

I want the health care choices I make later in this document to apply:

\_\_\_\_\_ Only if I have a terminal condition.

\_\_\_\_\_ Even if I do not have a terminal condition.

I want this directive to remain in effect after my death, for autopsy, organ donation, use of my body for medical research, and for my agent to arrange for the disposition of my remains, if I authorize that in section 9(e).

**2. MY HEALTH CARE AGENT**

I appoint as my agent:

Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_  
(day) (evening) (mobile)

My alternate agent {optional}:

If my agent is unable or unwilling to serve, or is unavailable, or if my agent is a spouse or partner from whom I am separated or divorced when decisions need to be made for me, then I name this alternate agent:

Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_  
(day) (evening) (mobile)

If my alternate agent acts for me because my first agent is unavailable, I intend that the alternate act only while my first agent is unavailable.

### 3. THE AUTHORITY I GIVE MY AGENT

I grant my agent complete authority to make all decisions about my health care. This includes, but is not limited to: (a) consenting, refusing consent, and withdrawing consent for medical treatment recommended by my physicians, including life-sustaining treatments; (b) requesting particular medical treatments; (c) accessing my medical records and information; (d) employing and dismissing health care providers; (e) changing my health care insurers; (f) making a Physician Orders for Life-Sustaining Treatment (POLST) form for me, and (g) removing me from any health care facility to another facility, a private home, or other place. This release authority additionally applies to information governed by the Health Insurance Portability and Accounting Act of 1996 as hereafter amended.

### 4. HOW TO MAKE HEALTH CARE DECISIONS FOR ME

I want whoever makes health care decisions for me to do as I would want in the circumstances, based on the choices I express in this document. If what I would want is not known, then I want decisions to be made in my best interest, based on (a) my values, (b) the contents of this document, and (c) medical information provided by my health care providers.

### 5. WHY I AM MAKING THIS DOCUMENT

I value life very much, but I believe that to be kept alive in certain circumstances is worse than death. I do not want others to substitute their choices for mine or for my agent's or other decision maker's because they disagree with them or because they think their choices are in my best interest. I do not want my intentions, as expressed by my agent or other decision maker for me, to be rejected because someone thinks that if I had more information when I completed this document, or if I had known certain medical facts that developed later, I would change my mind.

\_\_\_\_\_ I have completed and attached an additional statement of my values.

### 6. WHEN I DO NOT WANT LIFE-SUSTAINING TREATMENT

(a) \_\_\_\_\_ I have lived a long life and I am ready to accept death when it comes. For this reason, if I have or get any life-threatening condition, I do not want any treatment to try to "save" my life or keep me alive. Even if treatment might completely reverse a life-threatening condition and return me to the same health I had before, I do not want it.

◀ **STOP** see sidebar note

(b) These are qualities of life I consider worse than death, and in which I would want to be allowed to die:

\_\_\_\_\_ (1) Unconsciousness or coma from which the ability to think and communicate will probably not be recovered, or, unconsciousness lasting {insert number} \_\_\_\_\_ weeks, whichever comes first.

\_\_\_\_\_ (2) Apparently complete or nearly complete loss of ability to think and communicate, which is probably permanent.

\_\_\_\_\_ (3) Total dependence on others for my care because of physical deterioration, which is probably permanent.

If you do not designate a health care agent, the law authorizes someone else to make health care decisions for you.

If you wish to state other personal reasons for making this directive, use an additional page and initial the statement below. If not, put a dash in the space.

No additional statement is required.

Read all of section 6 before initialing.

**Caution:** Initialing section 6(a) means you do not want your life prolonged under any circumstances.

If you did initial 6(a), cross out all of sections 6(b) and 6(c) and go to section 7.

If you did not initial statement 6(a), cross it out and complete 6(b) and 6(c).

Initial statements that express your views.

Put a dash in any space you do not initial.

\_\_\_\_\_ (4) Pain which probably cannot be eliminated, or can be eliminated only by sedating me so heavily that I cannot converse.

\_\_\_\_\_ (5) Irreversible dementia such as Alzheimer's Disease.

**Part (6) is optional.**

**If this space is insufficient, write: "See attached page."**

**Any attached page should be signed, witnessed, and notarized, just as at the end of this document.**

\_\_\_\_\_ (6) Other circumstances in which I would not want life-sustaining treatment {describe}:

(c) TEMPORARY USE OF LIFE-SUSTAINING TREATMENT: I understand it is possible that I might experience an unacceptable quality of life – as initialed above or determined by my agent – at a time when my physician might believe temporary use of life-sustaining treatment would probably restore a quality of life acceptable to me. If so, then:

\_\_\_\_\_ (1) I want life-sustaining treatment, for up to {insert number} \_\_\_\_\_ week(s).

\_\_\_\_\_ (2) I still do not want life-sustaining treatment.

**Initial one statement, and put a dash in the other.**

## 7. LIFE-SUSTAINING TREATMENTS I DO NOT WANT

If I initialed 6a, or if I experience a condition I initialed in 6b, or if I experience a quality of life my agent believes I would consider unacceptable, I do not want these life-sustaining treatments started, and, if already in use, I want them stopped (except for temporary use if I authorized that in 6c).

**Initial any treatment you do not want.**

**Put a dash in any space you do not initial.**

\_\_\_\_\_ Nutrition and hydration other than ordinary food and water delivered by mouth, if I cannot eat and drink enough to sustain myself.

\_\_\_\_\_ All cardiopulmonary resuscitation (CPR) measures to try to restart my heart or breathing, if those stop, including, artificial ventilation, stimulants, diuretics, heart regulating drugs, or any other treatment for heart failure.

\_\_\_\_\_ Heart regulating drugs including electrolyte replacement, if my heartbeat becomes irregular.

\_\_\_\_\_ Surgeries to prolong my life.

\_\_\_\_\_ Blood dialysis or filtration to clean life-threatening substances from my blood, if my kidneys do not work normally.

\_\_\_\_\_ Transfusion of blood, plasma, blood products, or replacement fluids to replace lost or diseased blood.

\_\_\_\_\_ Medications, when their purpose is to prolong life rather than control pain (for example: antibiotics, chemotherapy, steroids, medicines to make my heart work, and insulin).

\_\_\_\_\_ Anything else intended to keep me alive.

## 8. MY WISHES CONCERNING COMFORT CARE AND PAIN MEDICATION

Initial "yes" or "no."

YES

NO

Do not leave blank.

If I appear to be in pain or experiencing symptoms such as breathlessness or I am otherwise uncomfortable, I want vigorous treatment to relieve my pain and symptoms and make me comfortable, even if my physicians or other medical providers believe this might unintentionally hasten my death, cause drug dependency, or make me unconscious.

\_\_\_\_\_

\_\_\_\_\_

## 9. MY WISHES CONCERNING OTHER MATTERS

Initial "yes" or "no."

YES

NO

Do not leave blank; you should have one set of initials per statement.

(a) I consent to medical treatments that are experimental.

\_\_\_\_\_

\_\_\_\_\_

(b) I want to donate organs/tissues.

\_\_\_\_\_

\_\_\_\_\_

(c) I consent to autopsy.

\_\_\_\_\_

\_\_\_\_\_

(d) I consent to use of all or part of my body for medical education or research.

\_\_\_\_\_

\_\_\_\_\_

(e) I want my remains to be disposed of as follows {describe}:

If you do not use section e, cross it out.

## 10. IF A COURT APPOINTS A GUARDIAN FOR MY PERSON, OR GENERAL GUARDIAN FOR ME

If a court appoints a guardian to make personal decisions for me and I have named a health care agent, I want my agent to be my guardian. If he/she cannot serve, then I want my alternate agent to be my guardian, if I have named an alternate. If the court decides to appoint someone else, I ask that the court require the guardian to consult with my agent (or alternate) concerning all health care decisions that would require my consent if I were acting for myself.

## 11. HOW THIS DIRECTIVE CAN BE REVOKED OR CANCELED

This directive can be revoked by a written statement to that effect, or by any other expression of intention to revoke. However, if I express disagreement with a particular decision made for me, that disagreement alone is not a revocation of this document.

## 12. SUMMARY AND SIGNATURE

I understand what this document means. If I am ever unable to make my own health care decisions, I am directing whoever makes them for me to do as I have said here. This includes withholding and/or withdrawing life-sustaining medical treatment, which might result in my death occurring sooner than if everything medically possible were done. I make this document of my free will, and I believe I have the mental and emotional capacity to do so.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## 13. STATEMENT OF WITNESSES

\_\_\_\_\_  
(Print your name – not the names of your witnesses – on this line.)

is personally known to me, and I believe him/her to be of sound mind and to have completed this document voluntarily. I affirm I am at least 18 years old, not related to him/her by blood, marriage, or adoption, and not his/her health care agent named in this document. As far as I know I am not a beneficiary of his/her will or any codicil, and I have no claim against his/her estate. I am not directly involved in his/her health care, and I am not an employee of his/her physician or a health care facility where the person making this document resides.

### WITNESS 1

\_\_\_\_\_  
Witness signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print witness name

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Address

### WITNESS 2

\_\_\_\_\_  
Witness signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print witness name

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Address

### NOTARY

STATE OF WASHINGTON

COUNTY OF \_\_\_\_\_

SUBSCRIBED AND SWORN TO before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

by the subscribing witnesses, and the grantor \_\_\_\_\_

\_\_\_\_\_  
Printed name

\_\_\_\_\_  
Signature

NOTARY PUBLIC in and for the State of Washington, residing at \_\_\_\_\_

\_\_\_\_\_  
My commission expires \_\_\_\_\_

**Sign on this line in the presence of your witnesses and a notary public.**

**Print your name on this line.**

**For information about who can or cannot be your witnesses, see section 13 of the Instructions.**

**For information about notarization, see section 13 of the Instructions.**



## TALKING TO YOUR FAMILY ABOUT DYING

If you want to ensure that your own death is peaceful, you must talk to your family, which includes your closest and most trusted family members, close friends, and perhaps a counselor. Even with the best of care, you probably won't be able to make all your medical decisions at the end, and you will want people you trust to make sure your wishes are followed.

Long before you need their help, you should begin talking with your family, preferably before you become terminally ill. They must know your wishes in advance for end-of-life care. The best way of doing this is to discuss your advance directives with them. Children don't like to talk about your dying, but it's not threatening to say, "I have no intention of dying soon, but it's important for you to understand my wishes – just in case something unexpected should happen."

By going through your directives carefully, your family will know how you want to die. Talk about your wishes for treatment should you become terminally ill or incapable of making decisions or permanently unconscious. Do this every two or three years, so that your family fully understands your directives and has opportunities to ask questions. Talking to your loved ones about dying also helps you know who will support you at the end.

If you become fatally ill, be sure your primary caregiver is very familiar with your advance directives, including a Physician Orders for Life Sustaining Treatment form or "POLST", if your state has one. (Note: Washington does offer POLST.) Tell your family your preference about dying in a nursing home, a hospital, or at home. Talk about hospice care. If you want no artificial life-support, such as a ventilator or a feeding tube or antibiotics for pneumonia, clearly say so. If your family fully understands your wishes well in advance, they will almost certainly follow them.

Talk about palliative care. If you want maximum pain control, tell your loved ones you will want enough medication to eliminate pain – even if it results in drowsiness or unconsciousness or, possibly, premature death. Tell them, if you wish, that if the medication cannot control your pain, you want continuous sedation to the end. These are not easy directives for caregivers to carry out, so they must have time to wrestle with them in advance, not when there is an immediate need.

Toward the end, when a reasonable quality of life is no longer feasible and you are ready to die, you must let your family know this. They may not understand your condition or share your decision to let go. They do not want to lose you, and some of them may feel that the best way to show their love for you is to "help you" by keeping you alive or convincing you to continue living. You must share with them your reasons and your determination to stop all attempts to cure the illness. Assure them that they and the doctors have done everything possible to reverse your course, and now it's time to work on a different level. Remember this: they are grieving for you, and grieving takes time. Everyone is different but, on average, it takes at least two months for a person to come to terms with the impending loss of a loved one.

By now, it should be clear that you must plan and talk in advance. Near the end there's one more bit of talking you should do. Tell your loved ones everything you want them to remember after you leave them. Ask them to forgive your past imperfections or wrongs in dealing with them, and tell them you forgive theirs. Connecting with your family at this time is the best way of showing your love for them and providing the emotional peace your family will need after you leave.