

**A Letter to My Primary Health Care  
Provider Concerning My Beliefs about End-of-Life Decisions**

Dear Dr. \_\_\_\_\_,

It is important to me to have excellent and compassionate care - to stay as healthy and active as possible over the course of my life. **At the end of life, my personal values and beliefs lead me to want treatment to alleviate suffering.** Most importantly, I want to ensure that if death becomes inevitable and imminent, the experience can be peaceful for me and my family.

If there are measures available that may extend my life, I would like to know their chance of success, and their impact on the quality of my life. If I choose not to take those measures, I ask for your continued support.

If my medical condition becomes incurable, and death the only predictable outcome, I would prefer not to suffer, but rather to die in a humane and dignified manner. I would like your reassurance that:

- If I am able to speak for myself, my wishes will be honored. If not, the requests from my health care representative and advance directives will be honored.
- You will make a referral to hospice as soon as I am eligible, should I request it.
- You will support me with all options for a gentle death, should I become terminally ill. This includes providing medications that I can self-administer, at the time of my choosing, to help me achieve a peaceful death. As you know, the State of Washington has enacted a Death with Dignity Law that authorizes a physician to prescribe medications to allow terminally ill patients to choose the time and manner of death.

I am not requesting that you do anything unethical while I am in your care, but I hope for your reassurance that you would support my personal end-of-life care choices as listed above.

**I hope you will accept this statement as a fully considered decision, and an expression of my deeply-held views. If you feel you would not be able to honor such requests, please let me know now,** while I am able to make choices about my care based on that knowledge.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Print  
Name: \_\_\_\_\_

*For additional information and forms regarding end-of-life care and choices, please visit: <http://www.candcofwa.org>*