

*The following letter can be used to help facilitate a conversation with your physician about aid in dying and end-of-life choices. This document is not an advance directive.*

## Letter to My Physician Concerning My Beliefs About End-of-Life Care

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

It is important to me to stay as healthy and active as possible and to have excellent and compassionate end-of-life care. My personal values and beliefs lead me to want treatment to alleviate suffering at the end of life. Most importantly, I want to ensure that, if I am terminally ill and if death is 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 healthcare representative and advance directives will be honored.
- You will make a referral to hospice as soon as I am eligible, if I request it.
- You will support me with all options for a gentle death, if 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 physicians to prescribe medications to allow terminally ill patients to choose the time and manner of death.

I hope you will accept this statement as a fully considered decision and an expression of my deeply held views. I hope for your reassurance that you would support my personal end-of-life care choices as listed above. 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:  
[www.CompassionWA.org](http://www.CompassionWA.org).