end of life
WASHINGTON
Your life. Your death. Your choice.

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

_____
{Your name here.}

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 make my own health care decisions. I understand that such inability may only be temporary. 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.

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.

1. MY HEALTH CARE AGENT

I appoint as my primary agent:

Name _____

Address _____

Telephone _____
(day) (evening) (mobile)

My alternate agent:

If my primary agent is unable or unwilling to serve, or, when decisions need to be made for me, my agent is a spouse or partner from whom I am legally separated or divorced and with whom I am no longer on good terms, then I name this alternate agent:

Name _____

Address _____

Telephone _____
(day) (evening) (mobile)

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If my alternate agent acts for me because my primary agent is unavailable, I intend that the alternate agent act only until my primary agent is available.

2. 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) employing and dismissing health care providers; (d) changing my health care insurers; (e) signing a Physician Orders for Life-Sustaining Treatment (POLST) form; (f) transferring me to another facility, private home, or other place; and (g) accessing my medical records and information. This authority applies to information governed by the Health Insurance Portability and Accounting Act (HIPAA) of 1996 and any further changes to HIPAA.

3. WHY I AM MAKING THIS DOCUMENT/ 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. I do not want others to substitute their choices for mine because they disagree with my choices or because they think their choices are in my best interest. I do not want my intentions 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. 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.

_____I have completed and attached an additional statement of my values.
{Optional}

4. WHEN I DO NOT WANT LIFE-SUSTAINING TREATMENT

I value life very much, but I believe that to be kept alive in certain circumstances is worse than death. These are the circumstances I consider worse than death, and for which I would want to be allowed to die include: {initial all that apply}

_____ a. Unconsciousness or coma that probably will prevent me from communicating, permanently.

_____ b. Irreversible dementia such as Alzheimer's Disease.

_____ c. Total dependence on others for my care because of physical deterioration, which is probably permanent.

_____ d. Pain which probably cannot be eliminated, or can be eliminated only by sedating me so heavily that I cannot converse.

_____ e. Below are other circumstances in which I would not want life-sustaining treatment:
{Optional}

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5. WHEN I MAY WANT TEMPORARY USE OF LIFE-SUSTAINING TREATMENT

I understand that I could become unconscious, or unable to communicate, *temporarily.* If I were to become unconscious or unable to communicate temporarily, then (initial only *ONE* line):

_____ I would want to receive life-sustaining treatment, for up to ____ weeks; *OR*

_____ I still would want no life-sustaining treatment.

6. LIFE-SUSTAINING TREATMENTS I DO NOT WANT

If I experience a condition in which I would not want life-sustaining treatment, or if I experience a quality of life my agent believes I would consider unacceptable, I do not want the following life-sustaining treatments started. If already started, I want them stopped.
{Initial all that you **do not** want.}

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

_____ Artificial ventilation when I can no longer breathe on my own.

_____ Heart-regulating drugs, if my heartbeat becomes irregular.

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

_____ Surgeries for the purpose of prolonging my life rather than for providing comfort.

_____ Dialysis if my kidneys do not work normally.

_____ Medications, treatments or procedures, when their primary purpose is to prolong life rather than control pain.

_____ Anything intended to prolong my life.

7. MY WISHES CONCERNING COMFORT CARE AND PAIN MEDICATION

	Yes	No
If I am experiencing symptoms such as pain, breathlessness, or visible discomfort, I want treatment to relieve my pain and symptoms and make me comfortable, even if medical providers believe this might unintentionally hasten my death, cause drug dependency, or make me unconscious.	_____	_____

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8. IF A HEALTH CARE PROVIDER REFUSES TO HONOR MY DECISIONS OR DECISIONS OF MY HEALTH CARE AGENT

(Cross out this section, if you do not agree.)

If I am ever in a health care facility that refuses to honor my decisions expressed in this document or decisions made for me by my health care agent, I want my agent to take whatever actions he or she decides are appropriate to secure those decisions, including but not limited to changing my physician(s) or moving me out of the facility.

9. MY WISHES CONCERNING OTHER MATTERS

	Yes	No
a. I consent to medical treatments that are experimental.	___	___
b. I want to donate organs/tissues.	___	___
c. I consent to an autopsy.	___	___
d. I consent to use of all or part of my body for medical education or research.	___	___

e. I have named the following individual(s) as my agent(s) for funeral arrangements:

My agent for funeral arrangements:

Name

Address

Telephone (day) (evening) (mobile)

My alternate agent for funeral arrangements (if my primary agent is unable or unwilling to serve, or if my agent is a spouse or partner from whom I am separated or divorced when decisions need to be made for me):
{optional}

Name

Address

Telephone (day) (evening) (mobile)

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f. I want my remains to be disposed of as follows: {describe}

10. IF A COURT APPOINTS A GUARDIAN FOR ME

If 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. I want this document to become effective, even if I become incompetent or otherwise disabled.

Signature _____ Date _____

{**Sign only in the presence of two witnesses** and a notary, if notarizing.}

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13. STATEMENT OF WITNESSES

_____

{**Print the legal name of the person making this document** 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 may reside.

WITNESS 1

_____ _____
Signature Date

_____ _____
Printed Name Phone

_____
Address

WITNESS 2

_____ _____
Signature Date

_____ _____
Printed Name Phone

_____
Address

NOTARIZATION {optional}

STATE OF WASHINGTON County of _____

I certify that I know or have satisfactory evidence that _____ signed this document and acknowledged it to be his/her free and voluntary act for the uses and purposes mentioned in this document.

Dated this _____ day of _____, 20 _____

_____
NOTARY PUBLIC in and for the State of Washington

Residing at _____

My commission expires _____

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