end of life WASHINGTON

Your life. Your death. Your choice.

MY INSTRUCTIONS FOR ORAL FEEDING AND DRINKING

I am making this document because I want my medical and long-term care providers, caregivers, family, and other loved ones to honor my wishes regarding oral feeding and drinking.

If I become unable make decisions about my health care and I stop feeding myself due to Alzheimer's Disease or other progressive dementia, I want oral food and fluids to be provided to me under certain circumstances.

If I accept food and drink (comfort feeding) when they're offered to me, I want them. I request that oral food and fluids be stopped if, because of dementia, any of the following conditions occur:

- I appear to be indifferent to being fed.
- I no longer appear to desire to eat or drink.
- I do not willingly open my mouth.
- I turn my head away or try to avoid being fed or given fluids in any other way.
- I spit out food or fluids.
- I begin a pattern of coughing, gagging, or choking on or aspirating (inhaling) food or fluids.
- The negative medical consequences or symptoms of continued feeding and drinking, as determined by a qualified medical provider, outweigh the benefits.

I want the instructions in this directive followed even if the person who has the right to make decisions for me and my caregivers judge that my quality of life, in their opinion, is satisfactory and I appear to them to be comfortable. I have given considerable thought to this decision and want my wishes to be followed.

No matter what my condition appears to be, I do not want to be cajoled, harassed, or forced to eat or drink. I do not want the reflexive opening of my mouth to be interpreted as giving my consent to being fed or given drink or misinterpreted as a desire for food or drink.

Before I am admitted to a long-term care facility, I want that facility to affirm its willingness to honor these instructions. If the long-term care facility where I already reside will not honor these instructions, I want to be transferred to one that will.

I want my wishes for life-sustaining treatment, including medically assisted artificial nutrition and hydration (for example, tube feeding, nasogastric tube, total parenteral nutrition) to be honored as documented in my health care directive or my Physician Orders for Life-Sustaining Treatment (POLST) form. If I did not make a health care directive or POLST form or they cannot be located, I want my health care agent's or other legal surrogate decision maker's decisions about life-sustaining treatment to be honored, including those addressing medically assisted artificial nutrition and hydration.

Signature | Printed Name | Date

Statement of Witnesses

The afore-named person 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 by blood, marriage, or adoption, and not the health care agent named in an Advance Directive for Health Care. As far as I know, I am not a beneficiary of his/her will or any codicil, and I have no claim against the estate. I am not directly involved in his/her health care, and I am not an employee of the 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 _____