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 communicate.

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 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 10.

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

5. WHY I AM MAKING THIS DOCUMENT

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

6. WHEN I DO NOT WANT LIFE-SUSTAINING TREATMENT

a. Qualities of life I consider worse than death, and in which I would want to be allowed to die: {initial all that apply}

_____ (1) Unconsciousness or coma from which the ability to think or communicate will probably not be recovered, or, unconsciousness lasting one _____ week(s), whichever comes first. {Insert number or "Dr's judgment."}

_____ (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.

_____ (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.

_____ (6) Other circumstances in which I would not want life-sustaining treatment: {Optional}

b. 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: {initial one}

_____ (1) I want life-sustaining treatment, for up to _____ week(s). {Insert number or "Dr's judgment."}

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

10. 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 designated agent(s) for funeral arrangements:

My designated agent:

_____
Name

_____
Address

_____
Telephone (day) (evening) (mobile)

My alternate agent: {optional}
If my primary 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)

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

11. IF A COURT APPOINTS A GUARDIAN FOR ME

7. LIFE-SUSTAINING TREATMENTS I DO NOT WANT

If I experience a condition I initialed in 6.a. 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 6.b.). {Initial all that you do not want.}

_____ 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.

_____ Transfusions of blood, plasma, blood products, or other 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

Yes	No
_____	____

9. REGARDING A HEALTH CARE INSTITUTION REFUSING TO HONOR MY WISHES

12. 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.

13. 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.}

14. 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 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 _____