Advance Directive – WASHINGTON

Name: _____Date of Birth: ____/____/____

Telephone numbers: (home) _____; (cell) _____

Address: _____

Email: _____

Complete at least **ONE** option from **Step 1** and **Step 2** and complete **Step 3**

Step 1: Choose a health care agent.

CHOOSE **ONE** OR **TWO** BOXES

☐ I choose _____; Relationship _____; (phone number - - and/or email _____) as my primary health care agent to speak for me in making health care decisions if I become unable to speak for myself.

☐ I choose _____; Relationship _____; (phone number - - and/or email _____) as my secondary health care agent who can speak for me in making health care decisions if I become unable to speak for myself and my primary health care agent is unable to serve.

Step 2: Provide guidance to my health care agent & doctors.

In working together to make treatment decisions and plans for my care, please consider my general preferences described below:

CHOOSE **ONE** BOX ONLY

☐ I am not sure at this time which statements below I most agree with. I trust my health care agent to do what is best for me.

☐ I want to continue living even if my quality of life seems low to others and I am unable to communicate with people. In general, I would accept support of my breathing, heart, and kidney function by machines that require me to be in a hospital or special care unit.

☐ Life is precious, but I understand that we all die sometime. I want to live as long as I can interact with others and can enjoy some quality of life. I would accept intensive treatments only if I had a reasonable chance of getting better. I would refuse long-term support by intensive medications or machines if my quality of life was poor and I was not able to communicate with people.

☐ It is most important to me to avoid suffering. I do not want extraordinary medical treatments, such as breathing machines or cardiopulmonary resuscitation (CPR). If my natural body functions fail, I would refuse treatments and choose to die naturally.

Is there anything your doctors should know about you to provide you with the best care possible?

_____

_____

Duration. This Advance Directive for Health Care becomes effective upon my incapacity. Incapacity shall include the inability to make health care decisions effectively for reasons such as mental illness, mental deficiency, incompetency, physical illness or disability, advanced age, chronic use of drugs or chronic intoxication. Incapacity may be determined by (a) a court order or (b) a written qualified attending physician. This Advance Directive for Health Care shall remain in effect to the fullest extent permitted by Chapter 11.125 of the Revised Code of Washington, or until revoked to terminate.

Step 3: Complete and sign the form in front of EITHER 1) two witnesses OR 2) notary public. By signing, I revoke any prior advance directive.

Signature _____ Date:_____

Address: _____

1. Option 1 – TWO Witnesses

I declare under penalty of perjury under the laws of Washington that:

- I was present when the individual signed this form.
- I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.
- I am not related to the individual executing this advance health care directive by blood, marriage, or adoption or state registered domestic partnership.

Signature _____

Name: _____

Address: _____

Date: _____

Signature _____

Name:_____

Address: _____

Date: _____

2. Option 2 – Notary

State of Washington
County of _____

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

Date: _____
Signature of Notary Public: _____
Title: _____
My appointment expires: _____

Name: _____ Date of Birth: _____

Instructions for Step 1: Appointing a health care agent.

Name someone you trust to make health care choices for you if you are unable to make your own decisions. Provide name and contact information for this person, along with one additional individual

Choose a family member or friend who:

- Is 18 or older and knows you well
- Is willing to do this for you
- Is able to make difficult decisions based on your wishes
- Will effectively communicate the information you provide in this packet to health

Your representative cannot be your doctor or someone who works at the hospital or clinic where you are receiving care unless he or she is a member of your family.

Your health care representative can:

- Decide where you will receive care
- Select or dismiss health care providers
- Say yes/no to medications, tests, treatments
- Take legal action to carry out your wishes

Your health care representative CANNOT authorize:

- Civil commitment
- Electro-convulsive therapy
- Psycho-surgery
- Other psychiatric treatment that restricts physical movement

Instructions for Step 2: Information for my health care agent & doctors in making decisions for my care.

Indicate your health care wishes

1. Select one of the choices to provide guidance concerning life support treatments. Below is some information about some life support treatments that may or may not be successful in helping you live longer.

   CPR or cardiopulmonary resuscitation: This may involve (1) Pressing hard on your chest to keep your blood pumping, (2) Electrical shocks to jump-start your heart, (3) Medicines in your veins.

   Ask your health care providers for more information as needed.

