



### **What is an advance directive?**

An advance directive tells your doctor what kind of care you would like to have if you become unable to make decision (if you are in a coma, for example). If you are admitted to the hospital, the hospital staff will probably talk to you about an advanced directive.

A good advanced directive describes the kind of treatment you would want depending on how sick you are. For example, the directives would describe what kind of care you want if you have an illness that you are unlikely to recover from, or if you are permanently unconscious. Advanced directives usually tell your doctor that you don't want certain kinds of treatment. However, they can also say that you want a certain treatment no matter how ill you are.

Advance directives can take many forms. Laws about advance directives are different in each state. You should be aware of the laws in your state.

### **What is a living will?**

A living will is one type of advance directive. It only comes into effect when you are terminally ill. Being terminally ill generally means that you have less than 6 months to live. In a living will, you can describe the kind of treatment you want in certain situations. A living will doesn't select someone to make decisions for you.

### **What is a durable power of attorney for health care?**

A durable power of attorney for health care (DPA) is another kind of advance directive. A DPA states whom you have chosen to make healthcare decisions for you. It becomes active any time you are unconscious or unable to make medical decisions. A DPA is generally more useful than a living will, but a DPA may not be a good choice if you don't have another person you trust to make these decisions.

Living wills and DPA's are legal in most states. Even if they aren't officially recognized by the law in your state, they can still guide your loved ones and doctor if you are unable to make decisions about your medical care. Ask your doctor, lawyer, or state representative about the laws in your state.

### **What is a do not resuscitate order?**

A do not resuscitate (DNR) order is another kind of advance directive. A DNR is a request not to have Cardiopulmonary resuscitation (CPR) if your heart stops or if you stop breathing. (Unless given other instructions, hospital staff will try to help all patients whose heart has stopped or who have stopped breathing). You can use an advance directive form or tell your doctor that you don't want to be resuscitated. In this case, a DNR order is put in your medical chart by your Doctor. DNR orders are accepted by doctors and hospitals in all states.

Most Patients who die in a hospital have had a DNR order written for them. Patients who are not likely to benefit from CPR include people who have cancer that has spread, people whose kidneys don't work well, people who need a lot of help with daily activities, or people who have severe infections such as pneumonia that require hospitalization. If you already have one or more of these conditions, you should discuss your wishes about CPR with your doctor, either in the doctor's office or when you go to the hospital. It's best to do this early, before you are very sick and are considered unable to make your own decisions.

### **Should I have an advanced directive?**

Most advanced directives are written by older or seriously ill people. For example, someone with terminal cancer might write that she does not want to be put on a respirator if she stops breathing. This action can reduce her suffering, increase her peace of mind and increase her control over her death. However, even if you are in good health, you might want to consider writing an advance directive. An accident or serious illness can happen suddenly, and if you already have a signed advance directive, your wishes are more likely to be followed.

Advance Directives and living wills do not have to be complicated documents. They can be short, simple statements about what you want done or not done if you can't speak for yourself. Remember, anything you write by yourself or with computer software package should follow your state laws. You may also want to have what you have written reviewed by your doctor or a lawyer to make sure your directives are understood exactly as you intended. When you are satisfied with your directives, the order should be notarized if possible, and copies should be given to your family and your doctor.

### **Can I change my advance directive?**

You may change or cancel your advance directive at any time, as long as you are considered of sound mind to do so. Being of sound mind means that you are still able to think rationally and communicate your wishes in a clear manner. Again, your changes must be made, signed and notarized according to the laws in your state. Make sure that your doctor and any family members who knew about your directives are also aware that you have changed them.

If you do not have time to put changes in writing, you can make them known while you are in the hospital. Tell your doctor and any family or friends present exactly what you want to happen. Usually, wishes that are made in person will be followed in place of the ones made earlier in writing. Be sure your instructions are clearly understood by everyone who has told.

# DURABLE POWER OF ATTORNEY FOR HEALTH CARE

## Notice to Person Executing This Document

**This is an important legal document. Before executing this document you should know these facts:**

- This document gives the person you designate as your Health Care Agent the power to make MOST health care decisions for you if you lose the capability to make informed health care decisions for yourself. This power is effective only when you lose the capacity to make informed health care decisions for yourself. As long as you have the capacity to make informed health care decisions for yourself, you retain the right to make all medical and other health care decisions.
- You may include specific limitations in this document on the authority of the Health Care Agent to make health care decisions for you.
- Subject to any specific limitations you include in this document, if you do lose the capacity to make an informed decision on a health care matter, the Health Care Agent *GENERALLY* will be authorized by this document to make health care decisions for you to the same extent as you could make those decisions yourself, if you had the capacity to do so. The authority of the Health Care Agent to make health care decisions for you *GENERALLY* will include the authority to give informed consent, to refuse to give informed consent, or to withdraw informed consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. You can limit that right in this document if you choose.
- When exercising his or her authority to make health care decisions for you when deciding on your behalf, the Health Care Agent will have to act consistent with your wishes, or if they are unknown, in your best interest. You may make your wishes known to the Health Care Agent by including them in this document or by making them known in another manner.
- When acting under this document the Health Care Agent *GENERALLY* will have the same rights that you have to receive information about proposed health care, to review health care records, and to consent to the disclosure of health care records.

## 1. Creation of Durable Power of Attorney for Health Care

I intend to create a power of attorney (Health Care Agent) by appointing the person or persons designated herein to make health care decisions for me to the same extent that I could make such decisions for myself if I was capable of doing so, as recognized by RCW 11.94.010. This designation becomes effective when I cannot make health care decisions for myself as determined by my attending physician or designee, such as if I am unconscious, or if I am otherwise temporarily or permanently incapable of making health care decisions. The Health Care Agent's power shall cease if and when I regain my capacity to make health care decisions.

## 2. Designation of Health Care Agent and Alternate Agents

If my attending physician or his or her designee determines that I am not capable of giving informed consent to health care, I \_\_\_\_\_, designate and appoint:

Name \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

as my attorney-in-fact (Health Care Agent) by granting him or her the Durable Power of Attorney for Health Care recognized in RCW 11.94.010 and authorize her or him to consult with my physicians about the possibility of my regaining the capacity to make treatment decisions and to accept, plan, stop, and refuse treatment on my behalf with the treating physicians and health personnel.

In the event that \_\_\_\_\_ is unable or unwilling to serve, I grant these powers to

Name \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

In the event that both \_\_\_\_\_ and \_\_\_\_\_

are unable or unwilling to serve, I grant these powers to

Name \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Your name (print) \_\_\_\_\_

**3. General Statement of Authority Granted.**

My Health Care Agent is specifically authorized to give informed consent for health care treatment when I am not capable of doing so. This includes but is not limited to consent to initiate, continue, discontinue, or forgo medical care and treatment including artificially supplied nutrition and hydration, following and interpreting my instructions for the provision, withholding, or withdrawing of life-sustaining treatment, which are contained in any Health Care Directive or other form of "living will" I may have executed or elsewhere, and to receive and consent to the release of medical information. When the Health Care Agent does not have any stated desires or instructions from me to follow, he or she shall act in my best interest in making health care decisions.

The above authorization to make health care decisions does not include the following absent a court order:

- (1) Therapy or other procedure given for the purpose of inducing convulsion;
- (2) Surgery solely for the purpose of psychosurgery;
- (3) Commitment to or placement in a treatment facility for the mentally ill, except pursuant to the provisions of Chapter 71.05 RCW;
- (4) Sterilization.

I hereby revoke any prior grants of durable power of attorney for health care.

**4. Special Provisions**

---



---



---



---



---

DATED this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
(Year)

GRANTOR \_\_\_\_\_

STATE OF WASHINGTON ) )ss.

(COUNTY OF \_\_\_\_\_)

I certify that I know or have satisfactory evidence that the GRANTOR, \_\_\_\_\_ signed this instrument and acknowledged it to be his or her free and voluntary act for the uses and purposes mentioned in the instrument.

DATED this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
(Year)

\_\_\_\_\_  
NOTARY PUBLIC in and for the State of Washington,

residing at \_\_\_\_\_

My commission expires \_\_\_\_\_

NOTE: Washington state does not require this directive to be notarized or witnessed. Since some states do require it to be notarized; you may want to do so in the event you travel out-of-state.

# HEALTH CARE DIRECTIVE

Directive made this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
(Year)

I, \_\_\_\_\_ being of sound mind, willfully, and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, and do hereby declare that:

- (A) If at any time I should have an incurable and irreversible condition certified to be a terminal condition by my attending physician, and where the application of life-sustaining treatment would serve only to artificially prolong the process of my dying, I direct that such treatment be withheld or withdrawn, and that I be permitted to die naturally. I understand "terminal condition" means an incurable and irreversible condition caused by injury, disease or illness that would, within reasonable medical judgment, cause death within a reasonable period of time in accordance with accepted medical standards.
- (B) If I should be in an irreversible coma or persistent vegetative state, or other permanent unconscious condition as certified by two physicians, and from which those physicians believe that I have no reasonable probability of recovery, I direct that life-sustaining treatment be withheld or withdrawn.
- (C) If I am diagnosed to be in a terminal or permanent unconscious condition, [*Choose one*]  
I want \_\_\_\_\_ do not want \_\_\_\_\_  
artificially administered nutrition and hydration to be withdrawn or withheld the same as other forms of life-sustaining treatment. I understand artificially administered nutrition and hydration is a form of life-sustaining treatment in certain circumstances. I request all health care providers who care for me to honor this directive.
- (D) In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this directive shall be honored by my family, physicians and other health care providers as the final expression of my fundamental right to refuse medical or surgical treatment, and also honored by any person appointed to make these decisions for me, whether by durable power of attorney or otherwise. I accept the consequences of such refusal.
- (E) If I have been diagnosed as pregnant and that diagnosis is known to my physician, this directive shall have no force or effect during the course of my pregnancy.
- (F) I understand the full import of this directive and I am emotionally and mentally competent to make this directive. I also understand that I may amend or revoke this directive at any time.
- (G) I make the following additional directions regarding my care:

---

---

---

---

Signed: \_\_\_\_\_

The declarer has been personally known to me and I believe him or her to be of sound mind. In addition, I am not the attending physician, an employee of the attending physician or health care facility in which the declarer is a patient, or any person who has a claim against any portion of the estate of the declarer upon the declarer's decease at the time of the execution of the directive.

Witness: \_\_\_\_\_

Witness: \_\_\_\_\_

### **What To Do With These Forms**

The attached Health Care Directive and Durable Power of Attorney for Health Care forms are all legal documents once they are completely filled out and signed with the appropriate signatures.

Signed copies of the completed directives should be included in your medical record, given to any person to whom you give your durable power of attorney—including any alternate people you may have named—and to your personal attorney. Originals should be kept by someone you trust and who can obtain them in an emergency.

### **For Further Information**

These forms have been provided as a public service by the Washington State Medical Association. You are encouraged to discuss the directives with your physician. Any legal questions you may have about the use and effect of these directives may be answered by an attorney.