# FORM for INFORMATION to create an ADVANCE HEALTHCARE DIRECTIVE

**THE INFORMATION YOU PROVIDE IN THIS FORM WILL BE INSERTED INTO AN ALREADY EXISTING TEMPLATE OF A DOCUMENT COMMONLY CALLED AN ADVANCE HEALTH CARE DIRECTIVE a/k/a LIVING WILL. THAT TEMPLATE WAS WRITTEN BY ATTORNEYS WHO SPECIALIZE IN THIS SUBJECT MATTER.** ONCE THE PERSON IDENTIFIED IN THE DOCUMENT AS THE "DECLARANT" SIGNS THAT DOCUMENT IN THE PRESENCE OF A NOTARY (EITHER IN PERSON OR VIA VIDEO CONFERNCE) AND IT IS THEN PROPERLY NOTARIZED, THE DIRECTIVE WILL BE CONSIDERED AN "EXECUTED" LEGAL DOCUMENT THAT MEDICAL PROFESSIONALS AND OTHERS CAN REFER TO AND RELY UPON. **THE DECLARANT CAN CHANGE OR CANCEL AN ADVANCE HEALTH CARE DIRECTIVE AT ANY TIME FOR ANY REASON.**

**IF NOT PERSONALLY FILLED OUT BY DECLARANT, PLEASE READ THE FOLLOWING OUT LOUD TO DECLARANT:** BY PROVIDING THE INFORMATION ASKED FOR ON THIS FORM, YOU AGREE THAT YOU ARE NOT CREATING AN ADVANCE HEALTHCARE DIRECTIVE JUST BECAUSE SOMEONE TOLD YOU TO, OR SUGGESTED IT; YOU AGREE THAT YOU HAVE DETERMINED YOU NEED TO CREATE AN ADVANCE HEALTHCARE DIRECTIVE FOR YOURSELF AFTER BECOMING INFORMED EITHER THROUGH RESEARCH OR RECEIVING COMPETENT ADVICE TO DO SO. YOU ALSO UNDERSTAND THAT ANYONE WHO HAS LEGAL QUESTIONS OR CONCERNS SHOULD ALWAYS CONTACT A QUALIFIED LEGAL PROFESSIONAL. **I AGREE:**

Declarant's Name:

FIRST M.I. (not required) LAST

Declarant's Contact Information

Address City State Zip

Phone Email

The ***health care advocate*** or ***agent*** is the person appointed to have the authority to make healthcare, custody, and medical treatment decisions on behalf of the Declarant if Declarant's attending and/or primary physician makes the determination that the Declarant is unable to make those decisions.

Usually, the advocate is the same person appointed to be the agent or "attorney in fact" for a medical power of attorney, but it is not required to be the same person.

DO YOU KNOW WHO WILL BE APPOINTED TO BE THE HEALTHCARE ADVOCATE IN THIS DOCUMENT?

NO →

AN ADVANCE HEALTHCARE DIRECTIVE CANNOT BE PRODUCED WITHOUT APPOINTING AN ADVOCATE. THIS WOULD BE A PERSON WHO SHOULD BE INFORMED OF YOUR DESIRE TO APPOINT THEM TO BE YOUR ADVOCATE; A PERSON YOU CONFIRM IS ABLE AND WILLING TO ACT IN THIS CAPACITY SHOULD THE NEED ARISE.

YES ↓

NAME:

FIRST M.I. LAST

Where do they live?

City St

THE ADVOCATE/AGENT NAMED ABOVE KNOWS ABOUT THIS APPOINTMENT AND HAS AGREED TO IT

YES

NO, not yet.

A *successor* health care advocate is someone who would step in to act as an alternate if the first person you appoint to be your advocate is unable to do so. A successor appointment is NOT required as part of an advance healthcare directive.

☐ I will not name any healthcare advocate successor(s) at this time. I understand I can do so at a later time so long as I am able to.

☐ I want my directive to name the following individual(s), in order, as alternate agent(s) should the person named on Page 1 be unable to act as my agent for any reason.

PLEASE MAKE SURE YOUR SPELLING IS CORRECT

| | | | | | | |
|---|---|---|---|---|---|---|
| 1st Successor: | FIRST | M.I. | LAST | Where do they live? | City | St |
| 2nd Successor: | FIRST | M.I. | LAST | Where do they live? | City | St |
| 3rd Successor: | FIRST | M.I. | LAST | Where do they live? | City | St |
| 4th Successor: | FIRST | M.I. | LAST | Where do they live? | City | St |
| 5th Successor: | FIRST | M.I. | LAST | Where do they live? | City | St |

AS YOU KNOW, AN ADVANCE HEALTHCARE DIRECTIVE IS A DETAILED SET OF STATEMENTS THAT REPRESENT THE DECLARANT'S WISHES IF, IN THE FUTURE, THE DECLARANT IS UNABLE TO CLEARLY STATE THOSE WISHES ON THEIR OWN. THIS RELATES SPECIFICALLY TO THE TYPE, OR LEVEL, OF MEDICAL CARE YOU WOULD LIKE TO RECEIVE UNDER CERTAIN CIRCUMSTANCES. **BY CLICKING "YES" OR "NO" FOLLOWING EACH OF THE STATEMENTS BELOW, "GENERAL DIRECTIVES" WILL BE INCLUDED IN THE DIRECTIVE INTENDED TO HELP PHYSICIAN(S) AND MEDICAL STAFF KNOW WHAT TO DO OR WHAT NOT TO DO UNDER THE CONDITIONS SPECIFIED IN EACH STATEMENT.**

In the event that I should be diagnosed with a terminal illness, disease, or injury, I wish to receive life-sustaining medical treatment to attempt to prolong my life.

YES NO

In the event that I should fall into a permanently unconscious state (coma or persistent vegetative condition), I wish to receive life-sustaining medical treatment in an attempt to prolong my life.

YES NO

In the event that I am diagnosed as being in a marginally conscious state, where I remain permanently unable to make decisions, I wish to receive life-sustaining medical treatment in an attempt to prolong my life.

YES NO

In the event that I am diagnosed as being in an untreatable condition or in severe pain, where no type of surgical or other relief can be obtained, I wish to receive life-sustaining medical care in an effort to try and prolong my life.

YES NO

## DIRECTION WITH RESPECT TO THE FOLLOWING SPECIFIC LIFE-SUSTAINING MEDICAL TREATMENTS

I wish to receive cardiac resuscitation (CPR) in an attempt to try and prolong my life.

YES NO

I wish to receive life-support (e.g., respirators, ventilators) used in an effort to replace or support my natural breathing.

YES NO

I wish to receive tube feeding or any other artificial or invasive form of nutrition (food) or hydration (water).

YES NO

I wish to receive blood or blood products.

YES NO

I wish to receive any form of surgery or invasive diagnostic tests.

YES NO

I wish to receive kidney dialysis.

YES NO

I wish to receive antibiotics or medication in an attempt to try and prolong my life.

YES NO

## DIRECTION WITH RESPECT TO COMFORT AND PAIN-RELIEF

[CHECK THE BOX NEXT TO THE ONE STATEMENT THAT MOST ACCURATELY REFLECTS YOUR WISHES AND DESIRES]

I wish to receive maximum pain-relief medication…

- ☐ No matter what, even if it may hasten my death
- ☐ As long as my attending physician determines it WILL NOT hasten my death
- ☐ I wish to direct my advocate, taking their best understanding of my values into consideration, to make this decision for me in consultation with my attending and/or primary care physician

If the maximum pain-relief medication may result in temporary addiction should I survive, recover or rebound from my current conditions and/or extended hospital stay…

- ☐ I accept that possibility. I would still choose maximum pain-relief.
- ☐ As long as my attending physician believes, in good faith, addiction is unlikely, or that the relief will outweigh the risk
- ☐ I wish to direct my advocate, taking their best understanding of my values into consideration, to make this decision for me in consultation with my attending and/or primary care physician

## DIRECTION WITH RESPECT TO APPOINTING A GUARDIAN

In the event that a guardian needs to be appointed to act in my best interests, I would like my healthcare directive to nominate the advocate (a/k/a agent) I identified on Page 1 of this form (or any successor I may name) to be appointed to act as my guardian.

["Yes" MEANS THE ABOVE STATEMENT ACCURATELY REPRESENTS YOUR WISHES AND DESIRES AND "No" MEANS IT DOES NOT]

YES NO

## DIRECTION WITH RESPECT TO CHOOSING WHETHER TO PROLONG LIFE UNDER CERTAIN CIRCUMSTANCES

[CHECK THE BOX NEXT TO THE ONE STATEMENT THAT MOST ACCURATELY REFLECTS YOUR WISHES AND DESIRES]

I direct my health care advocate, health care provider and others who may be involved in my health care to be aware that it is my wish and choice that my life be prolonged to the greatest extent possible within the limits of generally accepted health care standards.

It is my wish and choice that my life be prolonged to the greatest extent possible within the limits of generally accepted health care standards, ONLY UNDER CERTAIN CONDITIONS.

It is my wish and choice that UNDER NO CONDITIONS my life be prolonged to the greatest extent possible within the limits of generally accepted health care standards.

YOU ARE NOT REQUIRED TO CHECK ANY OF THE BOXES BELOW. IF YOU WISH FOR NO EFFORTS TO BE MADE TO PROLONG YOUR LIFE UNDER THE CIRCUMSTANCES LISTED, CHECK ALL THREE BOXES. IF NONE APPLY, CHECK NONE OF THE BOXES.

It is my wish and choice that my life NOT be prolonged if…

- ☐ I have an incurable or irreversible condition
- ☐ I become permanently unconscious or fall into a vegetative state
- ☐ The risks and burdens of prolonging life outweigh the benefits, as determined by my health care advocate after he or she has consulted with my attending and/or primary care physician and after he or she has taken their best understanding of my values into consideration

## ANATOMICAL GIFT - DONATION

It is Declarant's wish and desire that upon his or her death…

With respect to the above-described organs, tissues, and/or parts can be used for the following purposes:

Any purpose authorized or allowable by law

YES NO

IF DECLARANT WISHES FOR A PRIMARY CARE PHYSICIAN TO BE INCLUDED IN THIS DOCUMENT, PROVIDE THEIR NAME AND CONTACT INFORMATION HERE

## PRIMARY PHYSICIAN APPOINTMENT

Should I ever be diagnosed with a terminal illness, disease, injury, or should I become incapacitated or permanently unconscious (in a coma or persistent vegetative condition) where I would remain permanently unable to make decisions …

I wish to designate Dr. , as my primary health care

physician to provide and/or supervise all my health care needs on my behalf.

Name of Dr.'s office, clinic, hospital, or medical group:

Address City State Phone

**THIS DOCUMENT *IS NOT* AN ADVANCE HEALTH CARE DIRECTIVE**. WHEN THIS FORM IS COMPLETED AND SUBMITTED, THE INFORMATION YOU PROVIDE IS TRANSFERRED TO OUR TEMPLATE FORM FOR AN *ADVANCE HEALTHCARE DIRECTIVE* THAT WAS CREATED BY ATTORNEYS. WE WILL PRINT IT OUT FOR YOU AND DELIVER IT TO YOU FOR REVIEW. ONCE IT IS PROPERLY SIGNED AND DATED IN FRONT OF A NOTARY PUBLIC, THE DOCUMENT THEN BECOMES AN *ADVANCE HEALTHCARE DIRECTIVE* PURSUANT TO THE REVISED CODE of WASHINGTON (See RCW CHAPTER 70.122.010 to CHAPTER 70.122.920).

**REMINDER: NEVER SIGN ANY DOCUMENT WITHOUT READING IT AND UNDERSTANDING WHAT YOU ARE READING, INCLUDING HOW YOUR RIGHTS AND RESPONSIBILITIES MAY BE AFFECTED. RESEARCH THE ISSUES AND SEEK LEGAL COUNSEL FOR ANY LEGAL ADVICE OR ASSISTANCE NEEDED.**

THIS FORM IS TO BE COMPLETED BY, OR IN THE PRESENCE OF, THE PERSON FOR WHOM THE ADVANCE HEALTH CARE DIRECTIVE IS BEING CREATED, WITH THEIR DIRECT INPUT AND DECISION-MAKING. THE BELOW-NAMED PERSON CERTIFIES THAT HAS BEEN THE CASE.

IS THE PERSON WHO FILLED OUT THIS FORM THE DECLARANT FOR WHOM THE DOCUMENT IS BEING MADE? YES NO

Name of Person Who Filled-Out This Form IF OTHER THAN DECLARANT

FIRST M.I. (not required) LAST

Contact Information of the Person Who Filled-Out This Form IF OTHER THAN DECLARANT

Address City State Zip

Phone: Email:

Date Submitted:

PRIOR TO EXECUTING THE ADVANCE HEALTH CARE DIRECTIVE, THE DECLARANT MAY BE ASKED IF THEY REVIEWED THE INFORMATION PROVIDED ON THIS FORM PRIOR TO SUBMISSION AS WELL AS BEING WELL FAMILIAR WITH THE STATEMENTS AND DIRECTIVES CONTAINED IN THE ADVANCE HEALTH CARE DIRECTIVE AS ACCURATELY REFLECTING THE DECLARANTS' WISHES AND DESIRES.