ADVANCE DIRECTIVE: DURABLE POWER OF ATTORNEY FOR HEALTH CARE

This advance directive, a durable power of attorney for health care, allows you to name and prepare your health care agent. This form meets the requirements of Washington state law.

My Information:

FULL NAME: PRONOUNS (optional):

(i.e., he/she/they)

DATE OF BIRTH: / /

(mm/dd/yyyy)

NAMING A HEALTH CARE AGENT

The person I designate as my health care agent is:

FULL NAME: PRONOUNS (optional):

RELATIONSHIP: BEST PHONE: ( ) ALTERNATE PHONE: ( )

ADDRESS, CITY, STATE, ZIP:

The people I designate as my alternate agents are:

If the person listed above is unable or unwilling to make my health care decisions, then I designate the people listed below as my first and second alternate health care agents.

First Alternate

FULL NAME: PRONOUNS (optional):

RELATIONSHIP: BEST PHONE: ( ) ALTERNATE PHONE: ( )

ADDRESS, CITY, STATE, ZIP:

Second Alternate

FULL NAME: PRONOUNS (optional):

RELATIONSHIP: BEST PHONE: ( ) ALTERNATE PHONE: ( )

ADDRESS, CITY, STATE, ZIP:

Situations that may apply:

Initial next to the statements below that apply to you. You may draw a line through statements that do not apply to you. For more information: see the ACP Overview, visit ***www.HonoringChoicesPNW.org****, or talk with your health care provider.*

____ If I name my spouse or registered domestic partner as my health care agent and we later file for a dissolution, annulment, or legal separation; I want them to continue as my health care agent.

____ I am not naming a health care agent. By sharing my goals and values in this form, it will be considered a personal values statement and not an advance directive.

PREPARING A HEALTH CARE AGENT

What matters most to me?

This section helps you think about what matters most to you. This information can guide the people who matter to you — like your health care agent and loved ones — to make health care decisions for you if you cannot make them yourself. Consider sharing:

- What do you love to do, mentally and physically?
- How important is it for you to know who you are and who you are with?
- How important is communicating with family and friends to you?
- What does "living well" or "a good day" look like to you?
- What do you value most in your life?

The following is what matters most to me: *(Be specific. Add pages if needed.)*

What are my beliefs, preferences, and practices?

It is important for the people who matter to you—like your health care agent and loved ones—and your health care team to know about your beliefs, preferences, and practices. Consider sharing:

- What provides you support, comfort, and strength during difficult times?
- What medical treatments would you want or not want (e.g., blood transfusion, pain management, artificial feeding)?
- How are health care decisions made in your community, culture, or family?

The following beliefs, preferences, and practices are important to me: *(Be specific. Add pages if needed.)*

I would want the following person(s) contacted to support my beliefs, preferences, and practices: *(They will not have power to make health care decisions.)*

NAME: ROLE:

PHONE: ( ) ORGANIZATION:

PREPARING A HEALTH CARE AGENT

In answering the following questions, I am sharing my health care preferences. If I cannot make health care decisions for myself, I want my health care agent to use this information to guide their decisions. I understand that this information can guide my care, but it might not be possible to follow my wishes exactly in every situation.

CPR: What are my wishes?

Standard care in Washington state is to provide cardiopulmonary resuscitation (CPR) to people if their heart and breathing stop. This section can guide your health care agent and health care providers on whether to perform CPR if you are hospitalized and your heart and breathing stop (also known as "code status").

If I am hospitalized and my heart and breathing stop:

- ☐ I want CPR attempted.
- ☐ I want CPR attempted, unless there has been a change in my health, and I have:
  - Little chance of living a life that aligns with the goals and values I have stated in this form and/or discussed with my health care agent; or
  - A disease or injury that cannot be cured, and I am likely to die soon; or
  - Little chance of survival even if my heart is started again.
- ☐ I do not want CPR attempted. I want to be allowed to die naturally. *(Talk to your health care provider about a POLST form.)*

Life Support: What are my wishes?

Your response below is intended to guide your health care agent. Answering this question does not make this form a health care directive, which is a directive to withdraw or withhold life-sustaining treatment in specific situations under Washington state law. For more information, visit www.HonoringChoicesPNW.org or talk with your health care provider.

If I am so sick or injured that I am likely to die soon or am in a coma and unlikely to recover, I want my health care agent to:

- ☐ Use all life-support treatments to keep me alive even if there is little chance of recovery. I want to stay on life support.
- ☐ Try all life-support treatments that my health care providers think might help me recover. If the treatments do not work and there is little chance of living a life that aligns with my goals and values, I do not want to stay on life support. At that point, allow me to die naturally.
- ☐ Allow me to die naturally. I do not want to be on life support. If life-support treatments have been started, I want them to be stopped.
- ☐ I want my health care agent to decide for me.

Additional Directions

If I am dying and my medical care, support system, and resources allow, my preference would be to die:

- ☐ At my home or the home of a loved one (with hospice if desired).
- ☐ In a medical facility.
- ☐ I do not have a preference.
- ☐ Other (please describe): _____

If I am pregnant and cannot make health care decisions for myself, I would like my health care agent and health care providers to take the following into consideration as they make health care decisions on my behalf:

NAME: _____

DATE OF BIRTH: / / _____
(mm/dd/yyyy)

Additional Directions

Write any additional information you want your health care agent, health care providers, or others to know about your health care wishes. Please note that your wishes for organ donation and plans for your remains should be documented separately.

AUTHORIZING A HEALTH CARE AGENT

Statement of General Authority and Powers of My Health Care Agent: I authorize my health care agent to give consent for medical treatments when I cannot make my own decisions. I authorize my health care agent to carry out my wishes regarding life-support treatments such as a CPR, breathing machines, feeding tubes, blood transfusions, and kidney dialysis. This includes consent to start, continue, or stop medical treatment.

I attest to the following: I understand the importance and meaning of this durable power of attorney for health care (DPOA-HC). This form reflects my health care agent choices and my goals, values, and preferences. I have filled out this form willingly. I am thinking clearly. I understand that I can change my mind at any time. I understand I can revoke and replace this form at any time. I revoke any prior durable power of attorney for health care. I want this DPOA-HC to become effective if a physician or licensed psychologist determines I do not have the capacity to make my own health care decisions. This directive will continue as long as my incapacity lasts.

MY SIGNATURE: DATE:

ADDRESS, CITY, STATE, ZIP:

Witnesses or Notary Requirement

You must have your signature either witnessed by two people or acknowledged by a notary public.

OPTION 1 – TWO WITNESSES

Witness Attestation: I declare I meet the rules for being a witness.

WITNESS #1 SIGNATURE: DATE:

NAME PRINTED:

WITNESS #2 SIGNATURE: DATE:

NAME PRINTED:

Rules for Witnesses:

- Must be at least 18 years of age and competent.
- Cannot be related to you or your health care agent by blood, marriage, or state registered domestic partnership.
- Cannot be your home care provider or a care provider at an adult family home or long-term care facility where you live.
- Cannot be your designated health care agent.

OPTION 2 – NOTARY

STATE OF WASHINGTON)
)
COUNTY OF _____)

This record was acknowledged before me on this day of ,

by (name of individual):

Signature: Title: Exp:

NAME:

DATE OF BIRTH: / /
(mm/dd/yyyy)