

WASHINGTON
Advance Directive
Planning for Important Healthcare Decisions

Caring Connections
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org
800/658-8898

Caring Connections, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

Caring Connections tracks and monitors all state and federal legislation and significant court cases related to end-of-life care to ensure that our advance directives are up to date.

It's About How You LIVE

It's About How You LIVE is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

- L**earn about options for end-of-life services and care
- I**mplement plans to ensure wishes are honored
- V**oice decisions to family, friends and healthcare providers
- E**ngage in personal or community efforts to improve end-of-life care

Using these Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive healthcare.
2. These materials include:
 - Instructions for preparing your advance directive, please read all the instructions.
 - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

ACTION STEPS

3. You may want to photocopy these forms before you start so you will have a clean copy if you need to start over.
4. When you begin to fill out the forms, refer to the gray instruction bars - they will guide you through the process.
5. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.
6. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, healthcare providers and/or faith leaders so that the form is available in the event of an emergency.

INTRODUCTION TO YOUR WASHINGTON ADVANCE DIRECTIVE

This packet contains two legal documents that protect your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself:

- 1. The Washington Durable Power of Attorney for Health Care** lets you name someone to make decisions about your medical care—including decisions about life support—if you can no longer speak for yourself. The Durable Power of Attorney for Health Care is especially useful because it appoints someone to speak for you any time you are unable to make your own medical decisions, not only at the end of life.
- 2. The Washington Health Care Directive** lets you state your wishes about medical care in the event your attending physician determines that you have developed a terminal condition and can no longer make your own medical decisions. The Healthcare Directive also applies to conditions of permanent unconsciousness, like irreversible coma and persistent vegetative state, although another doctor must then agree with your attending physician's opinion.

Note: These documents will be legally binding only if the person completing them is a competent adult (at least 18 years old).

INSTRUCTIONS FOR COMPLETING YOUR WASHINGTON DURABLE POWER OF ATTORNEY FOR HEALTH CARE

Your attorney-in-fact is the person you appoint to make decisions about your medical care if you become unable to make those decisions yourself.

Whom should I appoint as my Attorney-in-fact?

Your attorney-in-fact may be a family member or a close friend whom you trust to make serious decisions. The person you name as your attorney-in-fact should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you.

The person you appoint as your attorney-in-fact **cannot** be:

- your doctor,
- an employee of your doctor, or
- an administrator, owner or employee of a healthcare facility in which you are a patient at the time you sign your Durable Power of Attorney for Healthcare.

However, if any of the individuals listed above is also your spouse, state registered domestic partner, adult child, brother or sister; you may appoint that individual to be your attorney-in-fact.

You can appoint an additional individual as your successor attorney-in-fact. The successor will step in if your first choice for attorney-in-fact is unable, unwilling or unavailable to act for you.

How do I make my Washington Durable Power of Attorney for Health Care legal?

Although the law does not explicitly require your Durable Power of Attorney for Health Care to be witnessed, we recommend that two adults sign the statement on the document indicating that you were of sound mind and under no duress when you signed the document. You may also want to have your Durable Power of Attorney for Health Care notarized.

Should I add personal instructions to my Washington Durable Power of Attorney for Health Care?

One of the strongest reasons for naming an attorney-in-fact is to have someone who can respond flexibly as your medical situation changes and deal with situations that you did not foresee. If you add instructions to this document, you might unintentionally restrict your attorney-in-fact's power to act in your best interest.

INSTRUCTIONS FOR COMPLETING YOUR WASHINGTON DURABLE POWER OF ATTORNEY FOR HEALTH CARE (CONTINUED)

Talk with your attorney-in-fact about your future medical care and describe what you consider to be an acceptable "quality of life." If you want to record your wishes about specific treatments or conditions, you should attach an additional sheet of personal instructions to your Washington Health Care Directive (living will).

What if I change my mind?

If you wish to revoke your Washington Durable Power of Attorney for Health Care, you should notify your attorney-in-fact and your healthcare provider in writing of your intent to revoke. If you are unable to write, you can have someone else write a statement for you explaining that you are unable to write, but want your Durable Power of Attorney for Health Care revoked.

INSTRUCTIONS FOR COMPLETING YOUR WASHINGTON HEALTH CARE DIRECTIVE

How do I make my Washington Health Care Directive legal?

In order to make your Health Care Directive legally binding, you must sign the document in the presence of two adult witnesses. The two witnesses **cannot** be:

- related to you by blood or marriage,
- entitled to any portion of your estate through the operation of law or through any will or codicil,
- a person who has a claim against your estate, or
- your attending physician, an employee of your attending physician, or an employee of a health facility in which you are a patient.

Can I add personal instructions to my Health Care Directive?

Yes. You can add personal instructions under section (h). *This is important because it is unclear when you would be considered "terminal" under Washington law.*

Caring Connections recommends that you add the statement, "I do not want life support if it is likely that my death would occur without its use and there is no reasonable expectation that I will regain the ability to make decisions and express my wishes." You may also want to refuse specific treatments by a statement such as, "I especially do not want cardiopulmonary resuscitation, a respirator or antibiotics," or emphasize pain control by adding instructions such as, "I want to receive as much pain medication as necessary to ensure my comfort, even if it may hasten my death."

If you have appointed an attorney-in-fact, it is a good idea to write a statement such as, "Any questions about how to interpret or when to apply my Health Care Directive are to be decided by my attorney-in-fact."

It is important to learn about the kinds of life-sustaining treatment you might receive. Consult your doctor.

What if I change my mind?

You may revoke your Health Care Directive at any time by:

- canceling, defacing, obliterating, burning, tearing or otherwise physically destroying your Directive or having another destroy it for you in your presence,
- executing a written and dated revocation, or
- orally expressing your intent to revoke your Directive.

COMPLETING YOUR WASHINGTON HEALTH CARE DIRECTIVE (CONTINUED)

What other important facts should I know?

A pregnant patient's Health Care Directive will not be honored due to restrictions in state law.

As of July 22, 2007, **state registered domestic partners** have the same access as married couples to certain rights and benefits, including those associated with health care decision-making and other issues related to illness, incapacity, and death. To enter into a state registered domestic partnership, the following requirements must be met:

1. both persons share a common residence;
2. both persons are at least 18 years of age and capable of consenting to the domestic partnership;
3. neither person is married or already in a domestic partnership with another person;
4. both of the following are true:
 - the persons are not nearer of kin to each other than second cousins, whether by whole or half blood, and
 - neither person is a sibling, child, grandchild, aunt, uncle, niece, or nephew to the other person;
5. either of the following are true:
 - both persons are members of the same sex; or
 - at least one of the persons is 62 years of age or older

WASHINGTON DURABLE POWER OF ATTORNEY FOR HEALTH CARE – PAGE 1 OF 2

INSTRUCTIONS

PRINT YOUR
NAME

PRINT THE NAME,
ADDRESS AND
TELEPHONE
NUMBER OF YOUR
FIRST CHOICE TO
ACT AS YOUR
ATTORNEY-IN-FACT

PRINT THE NAME,
ADDRESS AND
TELEPHONE
NUMBER OF YOUR
SECOND CHOICE TO
ACT AS YOUR
ATTORNEY-IN-FACT

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I understand that my wishes as expressed in my living will may not cover all possible aspects of my care if I become incapacitated. Consequently, there may be a need for someone to accept or refuse medical intervention on my behalf, in consultation with my physician.

Therefore,

I, _____,
as principal, designate and appoint the person(s) listed below as my
attorney-in-fact for health care decisions.

First Choice: Name: _____

Address: _____

City/State/Zip Code: _____

Telephone Number: _____

If the above person is unable, unavailable, or unwilling to serve, I
designate:

Second Choice: Name: _____

Address: _____

City/State/Zip Code: _____

Telephone Number: _____

1. This Power of Attorney shall take effect upon my incapacity to make my own health care decisions, as determined by my treating physician and one other physician, and shall continue as long as the incapacity lasts or until I revoke it, whichever happens first.

**WASHINGTON DURABLE POWER OF ATTORNEY FOR
HEALTH CARE - PAGE 2 OF 2**

2. The powers of my attorney-in-fact under this Power of Attorney are limited to making decisions about my health care on my behalf. These powers shall include the power to order the withholding or withdrawal of life-sustaining treatment if my attorney-in-fact believes, in his or her own judgment, that is what I would want if I could make the decision myself. The existence of this Durable Power of Attorney for Health Care shall have no effect upon the validity of any other Power of Attorney for other purposes that I have executed or may execute in the future.

3. In the event that a proceeding is initiated to appoint a guardian of my person under RCW 11.88, I nominate the person designated as my first choice (on page 1) to serve as my guardian. My second choice (on page 1) will serve as my guardian if the first person is unable or unwilling.

4. I make the following additional instructions regarding my care:

ADD PERSONAL
INSTRUCTIONS
(IF ANY)

By signing this document, I indicate that I understand the purpose and effect of this Durable Power of Attorney for Health Care.

Dated this _____ day of _____, 20____.

(date) (month) (year)

SIGN AND DATE
YOUR DOCUMENT

Signed: _____

The person named as principal in this document is personally known to me. I believe that he/she is of sound mind, and that he/she signed this document freely and voluntarily.

WITNESSING
PROCEDURE

Witness: _____

TWO WITNESSES
SIGN HERE

Witness: _____

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WASHINGTON HEALTH CARE DIRECTIVE – PAGE 1 OF 3

INSTRUCTIONS

PRINT THE DATE

PRINT YOUR NAME

Directive made this _____ day of _____, _____.
(date) (month) (year)

I, _____,
(name)

having the capacity to make health care decisions, willfully, and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, and do here by declare that:

(a) If at any time I should be diagnosed in writing to be in a terminal condition by the attending physician, or in a permanent unconscious condition by two physicians, 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 by using this form that a 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, and where the application of life-sustaining treatment would serve only to prolong the process of dying. I further understand in using this form that a permanent unconscious condition means an incurable and irreversible condition in which I am medically assessed within reasonable medical judgment as having no reasonable probability of recovery from an irreversible coma or a persistent vegetative state.

(b) In the absence of my ability to give directions regarding the use of such life-sustaining treatment, it is my intention that this directive shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and I accept the consequences of such refusal. If another person is appointed to make these decisions for me, whether through a durable power of attorney or otherwise, I request that the person be guided by this directive and any other clear expressions of my desires.

(c) If I am diagnosed to be in a terminal condition or in a permanent unconscious condition (check one):

- I DO want to have artificially provided nutrition and hydration.
- I DO NOT want to have artificially provided nutrition and hydration.

(d) 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.

INDICATE YOUR WISHES ABOUT ARTIFICIAL NUTRITION AND HYDRATION

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(e) I understand the full import of this directive and I am emotionally and mentally capable to make the health care decisions contained in this directive.

(f) I understand that before I sign this directive, I can add to or delete from or otherwise change the wording of this directive and that I may add to or delete from this directive at any time and that any changes shall be consistent with Washington state law or federal constitutional law to be legally valid.

(g) It is my wish that every part of this directive be fully implemented. If for any reason any part is held invalid it is my wish that the remainder of my directive be implemented.

(h) I make the following additional instructions regarding my care:

ADD PERSONAL
INSTRUCTIONS
(IF ANY)

ORGAN DONATION
(OPTIONAL)

ORGAN DONATION (OPTIONAL)

Under Washington law, an anatomical gift made by a donor and not revoked by the donor before death is irrevocable and does not require consent or concurrence of any person after the donor's death. The law also authorizes any reasonable examination necessary to assure the medical acceptability of the anatomical gift.

An anatomical gift may be made by a document of gift signed by the donor. If the donor cannot sign, the document of gift must be signed by another individual and by two witnesses, (one of whom must be a disinterested witness), all of whom have signed at the direction and in the presence of the donor and of each other, and state that it has been so signed.

An individual may amend or revoke an anatomical gift at any time by: (1) a signed statement in the same manner as a document of gift; (2) any form of communication during a terminal illness or injury addressed to at least two adults (at least one of whom is disinterested); or (3) later executed document of gift that amends or revokes a previous anatomical gift or a portion of an anatomical gift, either expressly or by inconsistency; or (4) destruction or cancellation of the document of gift, with the intent to revoke the gift.

An individual may refuse to make an anatomical gift by (1) a writing signed in the same manner as a document of gift, (2) a will, or (3) any form of communication during a terminal illness or injury addressed to at least two adults (at least one of whom is disinterested).

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When a person obtains or renews a license, he or she will be provided with a statement whereby they may certify their willingness to make an anatomical gift. Revocation suspension, expiration or cancellation of the license does not invalidate the gift.

Initial the line next to the statement below that best reflects your wishes. You do not have to initial any of the statements. If you do not initial any of the statements, your agent and your family will have the authority to make a gift of all or part of your body under Washington law.

INITIAL THE
STATEMENT THAT
BEST REFLECTS
YOUR WISHES

- I do not want to make an organ or tissue donation and I do not want my agent or family to do so.
- I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution:

Name of individual/organization: _____

SELECT ONE

Pursuant Washington law, I hereby give, effective upon my death

Any needed organ or parts.

The following part or organs listed below:

INITIAL ONE

Any legally authorized purpose.

Transplant or therapeutic purposes only.

SIGN YOUR NAME
AND PRINT YOUR
ADDRESS

Name: _____

Signed: _____

City, County, and State of Residence: _____

The declarer has been personally known to me and I believe him or her to be capable of making health care decisions.

TWO WITNESSES
SIGN HERE

Witness: _____

Witness: _____

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YOU HAVE FILLED OUT YOUR ADVANCE DIRECTIVE, NOW WHAT?

1. Your Washington Durable Power of Attorney for Healthcare and Healthcare Directive and are important legal documents. Keep the original signed documents in a secure but accessible place. Do not put the original documents in a safe deposit box or any other security box that would keep others from having access to them.
2. Give photocopies of the signed originals to your attorney-in-fact and successor attorney-in-fact, doctor(s), family, close friends, clergy and anyone else who might become involved in your healthcare. If you enter a nursing home or hospital, have photocopies of your documents placed in your medical records.
3. Be sure to talk to your attorney-in-fact and successor, doctor(s), clergy, and family and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.
4. If you want to make changes to your documents after they have been signed and witnessed, you should complete new documents.
5. Remember, you can always revoke one or both of your Washington documents. If you revoke your documents, make sure you notify your representative, successor representatives, your family and your doctors.
6. Be aware that your Washington documents will not be effective in the event of a medical emergency. Ambulance personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate order that states otherwise. These orders, commonly called "non-hospital do-not-resuscitate orders," are designed for people whose poor health gives them little chance of benefiting from CPR. These orders must be signed by your physician and instruct ambulance personnel not to attempt CPR if your heart or breathing should stop.

Currently not all states have laws authorizing non-hospital do-not-resuscitate orders. We suggest you speak to your physician for more information. **Caring Connections does not distribute these forms.**