

Advance Directive

WASHINGTON



# LIFE CARE planning

my values, my choices, my care

[kp.org/lifecareplan](http://kp.org/lifecareplan)

 KAISER PERMANENTE®

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500 NE Multnomah St., Suite 100, Portland, OR 97232.

# LIFE CARE planning

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Full name: \_\_\_\_\_

Medical record number: \_\_\_\_\_

## Introduction

This advance directive allows you to share your values, your choices, and your instructions about your future health care. This form may be used to:

- Name someone you trust to make health care decisions for you (your health care agent), OR
- Provide written instructions about your future health care, OR
- Both name a health care agent AND provide written instructions for future health care.

**Part 1** allows you to name a health care agent.

**Part 2** gives you an opportunity to share your values and what is important to you.

**Part 3** allows you to give written instructions about your future health care.

**Part 4** allows you to guide your agent's decision-making by stating your hopes and wishes.

**Part 5** allows you to make your advance directive legally valid in the state of Washington.

**Part 6** prepares you to share your wishes and this document with others.

You are free to modify this form or use a different form.

This advance directive will replace any advance directive you have completed in the past. In the future, if you want to cancel or change your named agent, you must do so in writing and sign that document, or you can inform your health care provider in person.

Full name: \_\_\_\_\_

Medical record number: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Mailing address: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Work phone: \_\_\_\_\_ Email: \_\_\_\_\_

## Part 1. My Health Care Agent

### Selecting a health care agent:

Choose someone who knows you well, whom you trust to honor your views and values, and who is able to make difficult decisions in stressful situations. Once you have selected your health care agent, take the time to discuss your views and treatment goals with that person.

If I am unable to communicate my wishes and health care decisions or if my health care provider has determined that I am not able to make my own health care decisions, I choose the following person(s) to represent my wishes and make my health care decisions.

My health care agent must make health care decisions that are consistent with my instructions in this document and my known desires. If my agent does not know my wishes, my agent must make health care decisions that he or she believes to be in my best interest, considering what he or she knows about my personal values.\*

This form serves as the durable power of attorney for health care under Washington law. It does not give my health care agent authority over financial matters.

### My primary (main) health care agent is:

Full name: \_\_\_\_\_ Relationship to me: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Work phone: \_\_\_\_\_ Email: \_\_\_\_\_

Mailing address: \_\_\_\_\_

\*The preceding 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

Need additional assistance?  
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Full name: \_\_\_\_\_  
Medical record number: \_\_\_\_\_

If I cancel my primary health care agent's authority or if my primary agent is not willing, able, or reasonably available to make a health care decision for me, I name the individuals below as my first and second alternate agents.

## First alternate health care agent:

Full name: \_\_\_\_\_ Relationship to me: \_\_\_\_\_  
Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_  
Work phone: \_\_\_\_\_ Email: \_\_\_\_\_  
Mailing address: \_\_\_\_\_

## Second alternate health care agent:

Full name: \_\_\_\_\_ Relationship to me: \_\_\_\_\_  
Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_  
Work phone: \_\_\_\_\_ Email: \_\_\_\_\_  
Mailing address: \_\_\_\_\_

## Powers of my health care agent:

**Unless I state otherwise, my health care agent has all of the following powers** when I am unable to speak for myself or make my own decisions:

- A. Make choices for me about my health care. This includes decisions about tests, medicine, and surgery. It also includes decisions to provide, not provide, or stop all forms of health care to keep me alive, including artificial nutrition (food) and hydration (water).
- B. Review and release my medical records as needed to make decisions.
- C. Decide which physician, health providers, and organizations provide my medical treatment.
- D. Arrange for and make decisions about the care of my body after death (including autopsy).

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Full name: \_\_\_\_\_  
Medical record number: \_\_\_\_\_

*Please provide any additional comments or restrictions to the previous section. (For example, you may name people you would or would not want to be involved in decisions on your behalf. You may also specify decisions you would not want your agent to make.) Attach additional pages if necessary.*

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## **Additional powers of my health care agent:**

*Check the box below if you want your agent to have the following power:*

I want my agent to continue as my health care agent even if a dissolution, annulment, or termination of our marriage or domestic partnership has been completed.

**Need additional assistance?**  
**[kp.org/lifecareplan](http://kp.org/lifecareplan)**

## Part 2. My Values

I want my agent and loved ones to know what matters most to me, so that they can make decisions about my health care that match who I am and what is important to me.

To give you a sense of what matters most to me, I'd like to tell you some things about myself, such as how I enjoy spending my time, whom I like to be with, and what I like to do. I'd also like to tell you about the circumstances that would make life no longer worthwhile for me.

### 1. If I were having a really good day, I would be doing the following:

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### 2. What matters most to me is:

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### 3. Life would no longer be worth living if I were not able to:

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## Part 3. My Health Care Instructions: My Choices, My Care

*In the situation below, we ask you to consider a sudden unexpected event. You will always speak for yourself if you are able; in this situation, you are unable to speak for yourself.*

If I become unable to communicate or make my own choices, I ask that my health care agent represent my choices as detailed below and that my doctors and health care team honor them. If my health care agent or alternate agents are not available or are unable to make decisions on my behalf, this document represents my wishes.

*Note: If you choose not to provide written instructions, your health care agent will make decisions based on your spoken directions. If your directions are unknown, your agent will make decisions based on what he or she believes is in your best interest, considering your values.*

### 1. Treatments to prolong life

#### Consider the following situation:

*You have a sudden accident or stroke.*

*Doctors have determined you have a brain injury, leaving you unable to recognize yourself or your loved ones. The doctors have told your agent and/or family that you are not expected to recover these abilities. Life-sustaining treatments, such as a ventilator (i.e., breathing machine) or a feeding tube are required to keep you alive. In this situation, what would you want?*

#### I would want to be kept comfortable and:

- choose one {
- I would want to STOP life-sustaining treatment. I realize this would probably lead me to die sooner than if I were to continue treatment.
  - I would want life-sustaining treatments to continue as long as possible.

*Please provide any additional instructions about life-sustaining treatments. For example, you may want to state a specific time period that you would want to be kept alive if there were no improvement to your health.*

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## 2. CPR (Cardiopulmonary resuscitation)

CPR is an attempt to bring you back to life when your heart and breathing have stopped. It may include chest compressions (forceful pushing on the chest to make the heart contract), medicines, electrical shocks, and a breathing tube.

You have a choice about CPR. CPR can save lives. It is not as effective as most people think. CPR works best if done quickly, within a few minutes, on a healthy adult. When CPR is performed, it can result in broken ribs, punctured lungs, or brain damage from lack of oxygen. \*If you would like additional information about CPR, please request the brochure called **CPR: My Choice**.

### In the event that your heart and breathing stop, what would you want?

- choose one** {
- I always want CPR attempted.
  - I never want CPR attempted but, rather, want to permit a natural death.<sup>†</sup>
  - I want CPR attempted unless the doctor treating me determines any of the following:
    - I have an incurable illness or injury and am dying, OR
    - I have no reasonable chance of survival if my heart or breathing stops, OR
    - I have little chance of survival if my heart or breathing stops and the process of resuscitation would cause significant suffering.

\* Research shows that if you are in a hospital and get CPR, you have a 26% chance of it working and you leaving the hospital alive.

1. Girotra, S., Nallamothu, B. K., Spertus, J. A., Li, Y., Krumholz, H. M., & Chan, P. S. (2012). Trends in survival after in-hospital cardiac arrest. *New England Journal of Medicine*, 367:1912-20. doi:10.1056/NEJMoa1109148
2. Benjamin, E. J., Virani, S. S., Callaway, C. W., Chamberlain, A. M., Chang, A. R., Cheng, S., Stroke Statistics Subcommittee. (2018). Heart Disease and Stroke Statistics-2018 Update: A Report from the American Heart Association. *Circulation*, 137(12), e67-e492. doi:10.1161/CIR.0000000000000558 [Cardiac Arrest information on pages e355-372]

<sup>†</sup> If you are certain you do not want CPR, please discuss other documents you may want to complete with your physician.

Full name: \_\_\_\_\_

Medical record number: \_\_\_\_\_

**Part 4. My Hopes and Wishes (Optional)****1. My thoughts and feelings about where I would prefer to die:**

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**2. I want my loved ones to know that if I am nearing my death, I would appreciate the following for comfort and support (prayers, rituals, music, etc.):**

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**3. Religious or spiritual affiliation:**

I am of the \_\_\_\_\_ faith, and am a member of (faith/spiritual community) in (city) \_\_\_\_\_,

(phone #) \_\_\_\_\_. I would like my agent to notify them if I am seriously ill or dying. I would like to include in my funeral, if possible, the following (people, music, rituals, etc.):

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Full name: \_\_\_\_\_

Medical record number: \_\_\_\_\_

## 4. Other wishes/instructions:

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### Pregnancy

A request to withdraw life sustaining treatment is not enforceable if your physician knows you are pregnant.

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

### Organ donation

If you are interested in donating organs when you die, you can declare your donor status when getting or renewing a driver's license or by registering through the donor registry found at [www.lcnw.org](http://www.lcnw.org).

## Part 5. Making This Document Legally Valid

To make your advance directive legally valid in Washington, your signature must be witnessed by either two witnesses or acknowledged before a Notary Public.

Choose EITHER:

### Two Witnesses

- Your witnesses cannot be related to you (by blood, marriage, or state registered domestic partnership).
- Your witness cannot be one of your healthcare providers.
- Sign in the presence of your witnesses.
- Witnesses will sign on page 11.
- You will sign on page 12.

OR

### Notary Public

- Do not sign this document unless you are with a Notary Public.
- Notary Public will sign on page 12. (Skip page 11.)
- You will sign on page 12.

### **Statement of Witnesses**

**STATEMENT OF WITNESSES:** I declare under penalty of perjury under the laws of Washington

- That the individual who signed or acknowledged this advance directive is personally known to me or that the individual's identity was proven to me by convincing evidence,
- That the individual signed or acknowledged this advance directive in my presence,
- That the individual appears to be of sound mind and under no duress, fraud, or undue influence,
- That I am unrelated to the individual by blood, marriage or state registered domestic partnership, and
- That I am not the individual's health care provider, or an employee of the individual's health care provider.

#### **Witness Number One:**

Print full name: \_\_\_\_\_

Address: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

#### **Witness Number Two:**

Print full name: \_\_\_\_\_

Address: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**MY SIGNATURE**

My name printed: \_\_\_\_\_

My Signature: \_\_\_\_\_ Date: \_\_\_\_\_

State of Washington )  
                        ) ss.  
County of         )

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

GIVEN under my hand and official seal this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
(print notary's name)

Notary Public in and for the State of Washington, residing at \_\_\_\_\_

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

## Part 6. Next Steps

Now that you have completed your advance directive, you should also take the following steps.

### Discuss:

- Review your health care wishes with the person you have asked to be your agent (if you haven't already done so). Make sure he or she feels able to perform this important job for you in the future.
- Talk to the rest of your family and close friends who might be involved if you have a serious illness or injury. Make sure they know who your health care agent is and what your wishes are.

### Give copies:

- Give your health care agent a copy of your advance directive.
- Give a copy of your advance directive to your doctor or your local Kaiser Permanente Member Services.
- Make a copy for yourself and keep it where it can be easily found.

### Take with you:

- If you go to a hospital or nursing home, take a copy of your advance directive and ask that it be placed in your medical record.
- Take a copy with you any time you will be away from home for an extended period of time.

### Review regularly:

- Review your health care wishes whenever any of the "Five D's" occur:

**Decade** — when you start each new decade of your life

**Death** — whenever you experience the death of a loved one

**Divorce** — when you experience a divorce or other major family change

**Diagnosis** — when you are diagnosed with a serious health condition

**Decline** — when you experience a significant decline or deterioration of an existing health condition, especially when you are unable to live on your own

### Changing your advance directive:

If your wishes change, fill out a new advance directive, tell your agent and your family, and provide a copy to Kaiser Permanente.

Full name: \_\_\_\_\_

Medical record number: \_\_\_\_\_

## Copies of this document have been given to:

- Primary (main) health care agent

Full name: \_\_\_\_\_

Telephone: \_\_\_\_\_

- Alternate health care agent #1

Full name: \_\_\_\_\_

Telephone: \_\_\_\_\_

- Alternate health care agent #2

Full name: \_\_\_\_\_

Telephone: \_\_\_\_\_

- Health care provider/clinic

Name: \_\_\_\_\_

Telephone: \_\_\_\_\_

- Others:

Name: \_\_\_\_\_

Telephone: \_\_\_\_\_

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