

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)

ADDRESS, CITY, STATE, ZIP: _____

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: _____

PREPARING A HEALTH CARE AGENT

Consider sharing the following. Be specific. Add pages if needed. Cross out any sections you prefer not to complete.

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.

- What do you love to do, mentally and physically, that you can't imagine living without (e.g., being able to care for yourself, staying in your own home, knowing who you are and who you are with, etc.)?
- What do you value most in your life?

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.

- What provides you support, comfort, and strength during difficult times (e.g., touch, music, temperature, environment, who is in the room, etc.)?
- Are there medical treatments you would want or not want? (e.g., blood transfusion, pain management, artificial feeding, etc.)?
- Do you have specific beliefs that you would like to guide your medical treatment?

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: _____

PRINTED NAME: _____

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

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 team 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 team 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 on a health care directive, visit www.washingtonlawhelp.org or talk with your physician or health care team.

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.
- Continue to try all life-support treatments that my health care team thinks might help extend my life (you can give a time frame for how long to continue to try all life support – days/weeks/months/years: _____).
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): _____

continued >

Additional directions *(continued)*

Additional information you want your health care agent, health care team, or others to know about your health care wishes. You may include a statement such as “At the time of my death I am/am not an organ donor and my wish is... (e.g., cremation, burial, human composting, etc.)” Note that your wishes for organ donation and plans for your remains may be documented separately.

AUTHORIZING A HEALTH CARE AGENT

Authority I give my agent: I grant my agent complete authority to make all decisions about my health care. This includes, but is not limited to (a) consenting, refusing consent, and withdrawing consent for medical treatment recommended by my physicians, including life-sustaining treatments; (b) requesting particular medical treatments; (c) employing and dismissing members of the health care team; (d) changing my health care insurers; (e) signing a Portable Orders for Life-Sustaining Treatment (POLST) form; (f) transferring me to or placing me in another facility, private home, or other places; and (g) accessing my medical records and information.

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: _____

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: _____

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: _____

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.

PRINTED NAME: _____

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