Advance Health Care Directive

WASHINGTON

LIFE CARE **planning**

my values, my choices, my care

kp.org/lifecareplan

KAISER PERMANENTE®

All plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest.
500 NE Multnomah St., Suite 100, Portland, OR 97232.

60418811_NW

Full name: _____
Medical record number: _____

Introduction

This advance health care 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 health care 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 health care directive will replace any advance health care 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: _____

Document type: Advance Directive

Full name: _____
Medical record number: _____

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 (as recognized by RCW 11.94.010).

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 does not give my health care agent the authority to make financial or other business decisions.

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

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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).

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.

_____

_____

_____

_____

_____

_____

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.

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Full name: _____
Medical record number: _____

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:

2. What matters most to me is:

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

Full name: _____
Medical record number: _____

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.

_____

_____

_____

_____

_____

Full name: _____
Medical record number: _____

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.†
- ❑ 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 17% chance of it working and you leaving the hospital alive. Peberdy MA, Kaye W, Ornato JP, et al. Cardiopulmonary resuscitation in adults in the hospital: A report of 14,720 cardiac arrests from the National Registry of Cardiopulmonary Resuscitation. Resuscitation - 2003; 58 297-308.

† 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:

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.):

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.):

Full name: _____
Medical record number: _____

4. Other wishes/instructions:

_____

_____

_____

_____

_____

_____

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 donatelifenw.org/register-now.

Full name: _____
Medical record number: _____

Part 5. Making This Document Legally Valid

To make your advance health care directive legally valid in Washington, it must be signed by 2 witnesses:

Two Witnesses

- Your witnesses cannot be related to you (by blood, marriage, or adoption) and cannot be entitled to any part of your estate.
- Witnesses cannot be your attending physician, an employee of the attending physician, or an employee of the health care facility in which you are a patient.
- When you are with your witnesses, sign or acknowledge your signature.
- Witnesses will sign on page 11.
- You will sign on page 12.

Full name: _____
Medical record number: _____

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 health care 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 health care directive in my presence,
- That the individual appears to be of sound mind and under no duress, fraud, or undue influence,
- That I am not appointed as an agent by this advance health care directive, and
- That I am not the individual's health care provider, an employee of the individual's health care provider, or an employee of the facility in which the declarer is a patient.

Witness Number One:

Print full name: _____

Address: _____

Signature: _____ Date: _____

Witness Number Two:

Print full name: _____

Address: _____

Signature: _____ Date: _____

Full name: _____
Medical record number: _____

MY SIGNATURE

My name printed: _____

My Signature: _____ **Date:** _____

Full name: _____
Medical record number: _____

Part 6. Next Steps

Now that you have completed your advance health care 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 health care directive.
- Give a copy of your advance health care directive to your doctor or your local Kaiser Permanente Education Department.
- 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 health care 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 health care directive:

If your wishes change, fill out a new advance health care 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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