WHAT TO DO WITH THESE FORMS

You should give a copy of the completed ADVANCE DIRECTIVE to your personal physician, as well as to a family member or a friend, to ensure that it will be available if it is needed. Your physician should have a copy of it placed in your medical records and should flag it so that anyone who might be involved in your care can be aware of its presence.

IMPORTANT NOTE

The standard operating procedure of most healthcare facilities assume you want life-sustaining procedures provided unless you indicate otherwise.

The DIRECTIVE TO PHYSICIANS (Living Will) deals with withholding or withdrawing medical treatments. It does not permit any active measure to deliberately end life, such as a lethal injection.

THE ADVANCE DIRECTIVE

As part of your right to make your personal health care decisions, you may accept or refuse any recommended medical treatment. This is relatively easy when you are well and can speak for yourself. Unfortunately, during severe illness, you may be unconscious or otherwise unable to communicate your wishes – at the very time when many critical decisions may need to be made. An ADVANCE DIRECTIVE communicates your wishes for medical care so that the choices people make on your behalf reflect your wishes. An ADVANCE DIRECTIVE is typically worded to only take effect upon your incapacity, but may be worded to take effect immediately (incapacity involves your inability to make decisions or express your wishes). You can change your ADVANCE DIRECTIVE anytime until you become unable to do so.

The materials in this packet are born in a spirit of respecting a full measure of human life for every person and in the commitment and desire for communication within the extended family. The purpose is to help you make these decisions early in your life before a problem arises. This packet is an invitation to talk with your family, physicians, and others with whom you are intimately involved so they know and understand your wishes. By holding these discussions while you are healthy, thinking clearly, and in control of your life, you can help your family to understand your feelings and carry out your wishes on a variety of serious concerns. This packet will present introductions to many of these concerns such as: cardiopulmonary resuscitation, mechanical breathing, artificial nutrition, and hydration. This is not intended to be a complete list of possible problems and concerns, but rather an introduction to open discussions with your family, physician, and others intimately involved in your care. Dying is one of life's most personal moments – it should be one of dignity.

You may also want to be in touch with others who can help you with your choices. Since such choices usually reflect personal, philosophical and religious views, you may want to discuss the issues with your clergy or a nurse, in addition to your family and your physician. Contact people are available at each hospital to assist you with questions on this packet. They can be reached by calling the following:

YAKIMA REGIONAL
Spiritual Care Department
575-5079

DIRECTIVE TO PHYSICIANS

I, _____, 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 hereby 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 expression 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** want to have artificially provided hydration only, and only to the extent it facilitates administration of medication to ease my comfort as I die.
[ ] **I DO NOT** want to have artificially provided nutrition and hydration.

(d) If I should suffer cardiac arrest, even if I am not in a terminal condition or in a permanent unconscious condition:

[ ] **I DO** want to have cardiopulmonary resuscitation (CPR) performed on me as directed herein.
[ ] **I DO NOT** want to have cardiopulmonary resuscitation (CPR) performed on me.

(e) 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.

(f) 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.

(g) 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.

(h) 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.

SIGNED at Yakima, Washington, this _____ day of _____, 20___.

_____

Each of us personally knows the person (the "Declarer") signing his/her name above, and we believe that person to be of sound mind. The signature above was made in the presence of both of us. Neither of us is related to the declarer by blood or marriage nor is either of us, to our knowledge, entitled to any portion of the declarer's estate upon the declarer's death, nor does either of us have any claim against any portion of the estate at this time. Neither of us is the attending physician, an employee of that physician, or an employee/volunteer of a health care facility in which the declarer is a patient.

_____ _____

Witness Witness

Print Name:_____ Print Name: _____

DURABLE POWER OF ATTORNEY FOR HEALTHCARE

1. DESIGNATION OF HEALTHCARE AGENT.

I, _____,
hereby appoint: _____,
Address:
City of _____State of _____ (zip code)
Phone: (_____) _____, as my attorney-in-fact ("Agent") to make health and personal care decisions for me. If _____ is deceased or is unable or unwilling to act, then _____ is designated as alternate attorney-in-fact to act for the Principal hereunder.

2. EFFECTIVE DATE AND DURABILITY.

By this instrument I intend to create a Durable Power-of-Attorney for HealthCare Decisions authorized by RCW 7.70.065 and 11.94.010(3). It shall take effective upon my incapacity to make my own healthcare decisions and shall continue during that incapacity to the extent permitted by law or until revoked in writing by me or my legal guardian. For purposes hereof, I will be deemed to be incapable of making my own healthcare decisions when in the reasonable judgment of the physician attending me I am not able to understand the consequences of certain medical care or treatment being given, withheld or withdrawn.

3. AGENT'S POWERS.

I grant to my Agent, full authority to make decisions for me regarding my healthcare. I direct my Agent to follow my desires as stated in this document or otherwise known to my Agent, and to attempt to discuss proposed decisions with me to determine my desires if I am able to communicate in any way. If my Agent cannot determine my wishes, then my Agent shall make a choice for me based upon what my Agent believes to be in my best interests. My Agent's authority is intended to be as broad as possible. Accordingly, unless specifically limited by Section 4 below, my Agent is authorized as follows:

A. To consent, refuse or withdraw consent to any and all types of medical care, treatment, surgical procedures, diagnostic procedures, medication, and the use of mechanical or other procedures that affect any bodily function, including (but not limited to) resuscitation; provided no such authority is granted to go against my express wishes as appear in my Directive To Physicians dated _____.

B. To have access to medical records and information to the same extent that I am entitled to, including the right to disclose the contents to others;

C. To authorize my admission to or discharge (even against medical advice) from any hospital, nursing home, residential care, assisted living or similar facility or service;

D. To contract on my behalf for any healthcare-related service or facility;

E. To hire and fire medical, social service and other support personnel responsible for my care;

F. To consent to and arrange for the administration of pain-relieving medications of any kind or for other surgical or medical procedures calculated to relieve my pain.

G. To take any other action necessary to do what I authorize here, including (but not limited to) granting any waiver or release from liability required by any hospital, physician, or other healthcare provider; signing any documents relating to refusals of treatment or the leaving of a facility against medical advice, and pursuing any legal action in my name and at the expense of my estate to force compliance with my wishes.

4. STATEMENT OF DESIRES, SPECIAL PROVISIONS AND LIMITATIONS.

A. Values Worksheet: In conjunction with the preparation of this Durable Power of Attorney For Healthcare, I have prepared a "Values Worksheet" with which I want my healthcare Agent to familiarize himself/herself. His/Her actions on my behalf with respect to healthcare should be carried out with those values in mind. (A true and accurate copy of the Values Worksheet is attached hereto and incorporated herein by this reference).

B. Special Provisions: Notwithstanding the expression of my values contained in my Values Worksheet, it is my request that my healthcare Agent adhere as much as practicable and possible to the following care provisions:

1) Continuum of Care Options:

a. I wish to retain an independent living arrangement as long as my physical and mental health permits.

[ ] Yes
[ ] No

b. In the event a completely independent living arrangement is no longer practicable, then I wish to have limited in-home assistance followed, if necessary, by full-time in-home assistance.

[ ] Yes
[ ] No

c. When I am no longer able to live in my home, then I wish to reside in an Assisted Living Facility, or an Adult Family Home.

[ ] Yes
[ ] No

d. It is my wish that I be placed in a nursing home only as a last resort when no other care options are applicable, or available, because of my particular physical/mental condition.

[ ] Yes
[ ] No

2. I want to live in a smoke free environment

[ ] Yes
[ ] No

3. I want my agent to keep my priest and/or clergy person advised of my condition on a regular basis:

[ ] Yes
[ ] No

C. Directive To Physicians: I specifically direct my Agent to follow my Directive to Physicians dated _____, a true and accurate copy of which is attached hereto and incorporated herein by this reference; or any amended versions of the same.

5. SUCCESSORS.

If any Agent named by me shall die, become legally disabled, resign, refuse to act, be unavailable, or (if Agent is my spouse) be legally separated or divorced from me, I name the following (each to act alone and successively in the order named) as successors to my Agent:

A. First Alternative Agent
Name:_____
Address:_____
_____

Telephone (_____) _____

B. Second Alternative Agent
Name:_____
Address:_____
_____

Telephone (_____) _____

6. NOMINATION OF GUARDIAN.

If a guardian of my person should for any reason be appointed, I nominate my Agent (or his or her successor), named above.

7. PROTECTION OF THIRD PARTIES WHO RELY ON MY AGENT.

No person who relies in good faith upon any representations by my Agent or Successor Agent shall be liable to me, my estate, my heirs or assigns, for recognizing the Agent's authority.

By signing here I indicate that I understand the content of this document and the effect of this grant of powers to my Agent.

I sign my name to this Durable Power of Attorney For Healthcare on this _____ day of _____, 20___.

_____
*Signature

Address: _____, Washington
(zip code)

WITNESSES:

Witness #1:	Witness #2:
Signature:_____	Signature:_____
Print Name: _____	Print Name: _____
Address: _____	Address: _____
_____	_____

VALUES WORKSHEET FOR:_____

The following are questions you may want to consider as you make decisions and prepare documents concerning your healthcare preferences. You may want to write down your answers and provide copies to family members and healthcare providers, or simply use the questions as food for thought and discussion.

How important to you are the following items?

	Very Important				Not Important
Letting nature take its course	4	3	2	1	0
Preserving my quality of life	4	3	2	1	0
Staying true to my spiritual beliefs and traditions	4	3	2	1	0
Living as long as possible, regardless of quality of life	4	3	2	1	0
Being independent	4	3	2	1	0
Being comfortable and as pain-free as possible	4	3	2	1	0
Leaving good memories for family and friends	4	3	2	1	0
Making a contribution to medical research or teaching	4	3	2	1	0
Being able to relate to family and friends	4	3	2	1	0
Being free of physical limitations	4	3	2	1	0
Being mentally alert and competent	4	3	2	1	0
Being able to leave money to family, friends, charity	4	3	2	1	0
Dying in a short while rather than lingering	4	3	2	1	0
Avoiding expensive care	4	3	2	1	0

What will be important to you when you are dying (e.g. physical comfort, no pain, family members present, etc.)?

How do you feel about the use of life-sustaining measures in the face of terminal illness? Permanent coma? Irreversible chronic illness or disability (e.g. Alzheimer's disease)?

Do you have strong feelings about particular medical procedures? Some procedures you may want to make decisions about include: mechanical breathing (respirator), cardio-pulmonary resuscitation (CPR), artificial nutrition and hydration (nutrition and fluid given through a tube in the veins, nose, or stomach), antibiotics, kidney dialysis, hospital intensive care, pain-relief medication, chemo or radiation therapy, and surgery.

Would your feelings about these procedures change depending on your health condition and prognosis? Would you want to avoid certain treatments only when death was certain, or also when you would probably be left extremely incapacitated as an outcome? Would you want to avoid certain treatments if they were used only to prolong the dying process, but accept them if they would alleviate pain?

What limitations to your physical and mental health would affect the healthcare decisions you would make?

Would you want to have financial matters taken into account when treatment decisions were made?

Would you want to be placed in a nursing home if your condition warranted?

Would you prefer hospice care, with the goal of keeping you comfortable in your home during the final period of life, as an alternative to hospitalization?

In general, do you wish to participate or share in making decisions about your healthcare and treatment?

Would you always want to know the truth about your condition?

Would you want to be an organ/tissue donor at the time of your death?

Do you have any pets that you wish to arrange care for during hospitalization or after your death?