預立醫療指示

ICHS International Community HEALTH SERVICES

關於預立醫療指示的資訊

您是否曾想過，當您生重病或受重傷時，希望獲得哪些健康照護？如果您無法表達自己的意願時，醫生和家人是否知道您想要的是甚麼？

本手冊編製的目的是協助您思考這些問題。

根據華盛頓州法規定，您有權做出關於自己健康照護的決定。您可透過「預立醫療指示」，表達自己想接受哪些健康護理。

甚麼是預立醫療指示？

預立醫療指示是一份正式的書面文件，在生重病之前寫下如果自己無法做決定時，希望選擇何種健康照護（即維持生命治療醫囑），或指定某人為您做出選擇（即醫療決定持久授權書）。透過預立醫療指示，您可以針對未來的醫療做出具法律效力的決定。

另一種表達意願的重要方式是與家人和醫生討論，告知您的意願。

本手冊提供關於填寫「維持生命治療醫囑」和「醫療護理永久授權書」表格的資訊。

预立醫療指示是否合法？

是的。有联邦和州法律管辖预立醫療指的使用。所有50个州和哥伦比亚特区都有法律承 认使用预立醫療指示。如果您旅行，希望您随身携带您的文件副本，因为其他州會承認这些文件。

预立醫療指示會在紧急情况下得到承認嗎?

不會，在大多数紧急情况下，紧急服务人员没有足够的时间来咨询患者的预立醫療指示。一旦患者接受医生的直接护理，就有时间對预立醫療指示進行評估和/或咨询医疗保健代理人。

甚麼是維持生命治療醫囑(POLST)？

維持生命治療醫囑（Physician Orders for Life-Sustaining Treatment，簡稱POLST）是一份表格，記錄醫師的指示，用於概要說明您對維持生命治療的意願。

這份表格可達成兩個主要目的：

- 在不同醫療機構之間通用。
- 將個人的意願轉變為實際醫囑。

POLST表格可促成將患者參與的臨終討論轉化為實際治療決定，並為個人和醫師提供保障，確保執行明文規定的意願。沒有任何其他表格可用這種方法來簡化此過程。

第6頁上有一份POLST副本。

如果沒有POLST呢？

是否要寫下指示，應視個人的決定。要讓其他人知道您的意願，最好的方式就是採取書面形式。有些人會覺得有書面的指示比較好。這樣一來，家人和朋友就無須擔負做決定的重責。

POLST可以修改嗎？

可以，您可以隨時修改或撤銷維持生命治療醫囑。您可以銷毀文件、寫下變更事項，或將變更事項告知醫生、護士和家人。如果您修改指示，請將新影本交給家人、醫生、律師或其他相關人等。您的醫生必須知道變更事項，否則變更事項將不具效力。

甚麼是維持生命的治療？

目前有幾種維持生命的治療和醫療程序可以延長生命，延後死亡的時間。我們希望您仔細思考，並與家人、朋友和醫生討論您的選擇。請務必讓其他人知道您的意願，以便在您無法自行做決定時有所依歸。

維持生命的治療不包括止痛的醫療程序或藥物。手术不包括在預立醫療指示中，您應与醫生討認這個問題 .放棄維持生命治療的決定並不影響提供舒緩和減輕疼痛的醫療照顧。舒緩和減輕疼痛的支持性醫療照護一定會提供。下列是其中一些維持生命的治療：

- 心肺復甦術（CPR)

  CPR 是在心臟或肺部突然停止運作時使用。這通常需要壓迫胸腔、使用藥物和（或）電擊來恢復心跳，以及插管來維持呼吸。CPR 對於某些病人來說可能並不適合 （例如因疾病末期面臨死亡的病人、長期處於植物人狀態的病人、或治療無望的病人），因為這只會延長死亡的過程。

- 呼吸器

  呼吸器是將空氣輸送到肺部的機器，幫助無法自行呼吸的病人呼吸。有時候在手術後或生病時，也會用到呼吸器。呼吸器可幫助病人呼吸，直到病人可自行呼吸為止。呼吸器對於疾病末期的病人來說可能並不適合，因為使用呼吸器可能只會延長死亡的過程。

- 人工營養和水份

  人工營養和水份是將食物或液體提供給無法進食或喝水的病人。食物和（或）液體可直接或間接進入胃部 （也稱為「胃管餵食法」） 或透過靜脈注射給予。這些方法通常是在暫時失去進食或消化功能時使用。當死亡已經確定或無治癒希望時，使用人工營養和水份可能只會延長死亡的過程。

This form is for information only and is not an official copy of the POLST.
The official copy will be a green form signed by you and your provider.

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

Last Name - First Name - Middle Name or Initial

Date of Birth ____ ____ ____

Last 4 #SSN (optional) ____ ____ ____ ____

FIRST follow these orders, **THEN** contact physician, nurse practitioner or PA-C. The POLST is a set of medical orders intended to guide medical treatment based on a person's current medical condition and goals. Any section not completed implies full treatment for that section. Completing a POLST form is always voluntary. Everyone shall be treated with dignity and respect.

Medical Conditions/Patient Goals:

Agency Info/Sticker

A — Cardiopulmonary Resuscitation (CPR): Person has no pulse and is not breathing.

Check One

- ☐ **Attempt Resuscitation/CPR** — When not in cardiopulmonary arrest, go to part B.
- ☐ **Do Not Attempt Resuscitation/DNAR (Allow Natural Death)**
  Choosing DNAR will include appropriate comfort measures.

B — Medical Interventions: Person has pulse and/or is breathing.

Check One

- ☐ **FULL TREATMENT - primary goal of prolonging life by all medically effective means.**
  Includes care described below. Use intubation, advanced airway interventions, mechanical ventilation and cardioversion as indicated. **Transfer** *to hospital if indicated. Includes intensive care.*
- ☐ **SELECTIVE TREATMENT - goal of treating medical conditions while avoiding burdensome measures.**
  Includes care described below. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not intubate. May use less invasive airway support (e.g. CPAP, BiPAP). **Transfer** *to hospital if indicated. Avoid intensive care if possible.*
- ☐ **COMFORT-FOCUSED TREATMENT - primary goal of maximizing comfort.**
  Relieve pain and suffering with medication by any route as needed. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. **Patient prefers no hospital transfer:** *EMS consider contacting medical control to determine if transport is indicated to provide adequate comfort.*

Additional Orders: (e.g. dialysis, etc.) _____

C — Signatures: The signatures below verify that these orders are consistent with the patient's medical condition, known preferences and best known information. If signed by a surrogate, the patient must be decisionally incapacitated and the person signing is the legal surrogate.

Discussed with:
- ☐ Patient
- ☐ Parent of Minor
- ☐ Guardian with Health Care Authority
- ☐ Spouse/Other as authorized by RCW 7.70.065
- ☐ Health Care Agent (DPOAHC)

PRINT — Physician/ARNP/PA-C Name | Phone Number

✗ Physician/ARNP/PA-C Signature ***(mandatory)*** | Date ***(mandatory)***

PRINT — Patient or Legal Surrogate Name | Phone Number

✗ Patient or Legal Surrogate Signature ***(mandatory)*** | Date ***(mandatory)***

Person has:
- ☐ Health Care Directive (living will)
- ☐ Durable Power of Attorney for Health Care

Encourage all advance care planning documents to accompany POLST

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Revised 8/2017

Photocopies and faxes of signed POLST forms are legal and valid. May make copies for records.
For more information on POLST visit www.wsma.org/polst.

WASHINGTON

WSMA Washington State Medical Association
Physician Driven Patient Focused

Washington State Department of Health

See back of form for non-emergency preferences ▶

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Patient and Additional Contact Information (if any)

Patient Name (last, first, middle)	Date of Birth	Phone Number
Name of Guardian, Surrogate or other Contact Person	Relationship	Phone Number

D NON-EMERGENCY MEDICAL TREATMENT PREFERENCES

ANTIBIOTICS:

☐ Use antibiotics for prolongation of life.
☐ Do not use antibiotics except when needed for symptom management.

MEDICALLY ASSISTED NUTRITION:

Always offer food and liquids by mouth if feasible.

☐ No medically assisted nutrition by tube.
☐ Trial period of medically assisted nutrition by tube. (Goal: _____)
☐ Long-term medically assisted nutrition by tube.

ADDITIONAL ORDERS: (e.g. dialysis, blood products, implanted cardiac devices, etc. Attach additional orders if necessary.)

✗ Physician/ARNP/PA-C Signature	Date
✗ Patient or Legal Surrogate Signature	Date

DIRECTIONS FOR HEALTH CARE PROFESSIONALS

NOTE: A person with capacity may always consent to or refuse medical care or inverventions, regardless of information represented on any document, including this one.

Completing POLST

- Completing a POLST form is always voluntary.
- Treatment choices documented on this form should be the result of shared decision-making by an individual or their surrogate and medical provider based on the person's preferences and medical condition.
- POLST must be signed by a physician/ARNP/PA-C and patient, or their surrogate, to be valid. Verbal orders are acceptable with follow-up signature by physician/ARNP/PA-C in accordance with facility/community policy.

Using POLST

Any incomplete section of POLST implies full treatment for that section.

This POLST is valid in all care settings including hospitals until replaced by new physician's orders.

The POLST is a set of medical orders. The most recent POLST replaces all previous orders.

The POLST does not replace an advance directive. An advance directive is encouraged for all competent adults regardless of their health status. An advance directive allows a person to document in detail his/her future health care instructions and/or name a surrogate decision maker to speak on his/her behalf. When available, all documents should be reviewed to ensure consistency, and the forms updated appropriately to resolve any conflicts.

SECTIONS A AND B:

- No defibrillator should be used on a person who has chosen "Do Not Attempt Resuscitation."
- When comfort cannot be achieved in the current setting, the person should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- An IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort-Focused Treatment."
- Treatment of dehydration is a measure which may prolong life. A person who desires IV fluids should indicate "Selective" or "Full Treatment."

SECTION D:

- Oral fluids and nutrition must always be offered if medically feasible.

Reviewing POLST

This POLST should be reviewed periodically whenever:

(1) The person is transferred from one care setting or care level to another, or
(2) There is a substantial change in the person's health status, or
(3) The person's treatment preferences change.

To void this form, draw line through "Physician Orders" and write "VOID" in large letters. Any changes require a new POLST.

Review of this POLST Form

Review Date	Reviewer	Location of Review	Review Outcome
			☐ No Change ☐ Form Voided ☐ New form completed
			☐ No Change ☐ Form Voided ☐ New form completed

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Photocopies and faxes of signed POLST forms are legal and valid. May make copies for records.

OVER ▶

For more information on POLST visit www.wsma.org/polst.

器官與組織捐贈

如果您希望捐贈器官和（或）組織，可以在醫療指示中註明。您可以向地方的聯邦指定器官捐贈組織 LifeCenter Northwest Organ Donation Network 登記，請上網 www.lcnw.org 或致電 1-877-275-5269 登記。當您申請或更換駕照時，也可以向機動車輛管理局（Department of Motor Vehicles）登記為捐贈者。駕照會印有捐贈者的標誌。登記之後，表示您選擇在死亡時捐出指定的器官和組織，以供移植或研究來幫助其他人。如果您登記為捐贈者，進行捐贈事宜時就不需要另外取得同意。

無論是否為捐贈者，請務必與家人討論您的決定。如果沒有指示或登記記錄，您的家人可能會被要求代替您做決定。為確保您的意願受到尊重，請務必將您的決定清楚告知家人，以便家人在您死亡時能夠支持您的決定。

如果我沒辦法做醫療決定，誰可以做決定？

依華盛頓州法律規定，如果您無法自行做決定，將由下列人士依順序替您做決定：

1. 監護人（如有指定）
2. 醫療決定持久授權書上的指定人士
3. 配偶/登記同居伴侶
4. 成年子女
5. 父母
6. 成年兄弟和（或）姊妹

被選為代替您做決定的人士必須依州法，按照指示中的意願行事。

甚麼是醫療決定持久授權書？

醫療決定持久授權書是一份文件，讓您指定某人在您無法自行做醫療決定時，代替您做出決定。您可以指示想要或不想要任何治療，例如手術、給予人工營養和水份（例如液體或藥物）。您可以選擇是否要由律師協助擬訂醫療決定持久授權書。您的代表應瞭解並尊重您的意願。

如何準備醫療決定持久授權書？

1. 詳閱下一頁上的醫療決定持久授權書表格。考慮是否要修改表格。仔細想想您要在其中加入哪些特殊的指示，以限制或指示您的代表。將這些指示寫下或列印出來，然後附在表格上。
2. 選擇要成為您的代表的人士。取得該人士的同意，成為醫療授權書的指定人。請直接告知該人士您想要其為您做哪些決定。
3. 在表格上簽名並加註日期。签署及写上日期，　并与两名符合條件的証人签名或得到公証。
4. 影印醫療決定持久授權書，自己、您的代表、家人和律師 （如有） 各保管一份影本。將醫療決定持久授權書正本交給醫生。醫療決定持久授權書必須與醫生保管的病歷放在一起，以確定醫生能夠依您的意願行事。

預立醫療指示可以修改嗎？

可以，您可以隨時修改或撤銷醫療指示或醫療決定持久授權書。您可以銷毀文件、寫下變更事項，或將變更事項告知醫生、護士和家人。如果您修改指示，請將新影本交給家人、醫生、律師或其他相關人等。您的醫生必須知道變更事項，否則變更事項將不具效力。

關於以下人士的
持久性醫療保健授權書

_____
[My Name]/[我的姓名]

1. **代理人。** 我選擇 _____做我的代理人，其有完全的權力來管理我的醫療保健事宜。

2. **後備代理人。** 如果_____無法或不願意採取行動，我選擇_____作為我的後備代理人，其有完全的權力管理我的醫療保健事宜。

3. **我的權力。** 祇要我有能力，我保留為自己做醫療保健決定的權力。

4. **持久性。**我的代理人可以使用這份授權書所授予之權力來管理我的事務，即使我生病或受傷，不能為自己做決定。 本授權書不應該因我的殘疾而受影響。

5. **開始日期。** 該授權書於我在公證人面前簽署之日起生效。

6. End Date. **結束日期。一旦**我撤銷了這份授權書，或者我過世了，該授權書將結束無效。 如果我的配偶或家庭伴侶是我的代理人，在我們當中的任何一位在法庭提出離婚時，這份授權書即結束無效。
7. **撤銷。** 我撤銷了我過去簽署過的其他任何醫療保健授權書。我知道我可以隨時通過書面方式，通知我的代理人撤銷這份授權書。

8. **權力。**我的代理人有完全的權力和權利，可以完全和有效地做任何事情，正如我可以做我自己的一樣，包括了做出保健護理決定和對我的醫療保健做出知己知彼的同意，拒絕和撤回就我醫療保健做出的同意，僱用和解僱我的醫療保健提供者，申請並同意我進入非心理治療的醫療、護理、居住或其他類似設施，根據已修改的醫療保險可攜帶性和責任法案（HIPAA）就所有事項作為我個人的代表，並到我居住的或接受治療的任何醫院或其他醫療設施拜訪我。

9. **心理健康治療。**我的代理人無權就我對心理健康治療或設施的承諾做出安排。我的代理人沒有被授權同意電驚厥治療、精神外科或其他限制身體行動自由的心理醫療程序。

10. **無權力同意有約束力的爭議前仲裁。** 我認識到，某些長期護理提供者會要求我或我的代理人簽署有約束力的爭議前仲裁協議。 這些協議限制了我在任何損傷或爭議發生之前起訴提供者的權力。 我認為這些協議是不公平和不可接受的。 因此，我的代理人沒有權力同意爭議前有約束力的仲裁，或涉及我個人或財產的任何其他程序，其限制我獲得陪審團審訊、起訴賠償或參加集體訴訟的權力。

11. **會計。** 我的代理人應該保存我財務的準確記錄，並根據我的請求顯示這些記錄。
12. **監護人提名。** 如果監護訴訟成為必需程序，我提名我的代理人作為我個人的監護人，供法院考慮

1. **醫療保險可攜帶性和責任法案（HIPAA）的發佈。** 我授權我的醫療保健提供者將所有受
1996年醫療保險可攜帶性和責任法案（HIPAA）管轄的信息發給我的代理。

_____ _____

My Signature 我的签名 Date 日期

Witness 1 **證人一** Witness 2 **證人二**

_____ _____

Signature 簽名 Signature 簽名

_____ _____

Name 姓名 Name 姓名

_____ _____

Address 地址 Address 地址

Notarization/**公證（optional, but recommended ）/公證（選擇性，但建議使用）**

State of Washington
County of _____

I certify that I know or have satisfactory evidence that_____, is the person who appeared before me, signed above, and acknowledged that the signing was done freely and voluntarily for the purposes mentioned in this instrument.

SUBSCRIBED and SWORN to before me on_____.

_____
SIGNATURE OF NOTARY

_____
PRINT NAME OF NOTARY
NOTARY PUBLIC for the State of Washington.
My commission expires_____.

HEALTH CARE DIRECTIVE

Directive made this _____ day of _____, _____.
(Year)

I, _____ being of sound mind, 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 have an incurable and irreversible condition certified to be a terminal condition by my attending physician, 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 "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.

(B) If I should be in an irreversible coma or persistent vegetative state, or other permanent unconscious condition as certified by two physicians, and from which those physicians believe that I have no reasonable probability of recovery, I direct that life-sustaining treatment be withheld or withdrawn.

(C) If I am diagnosed to be in a terminal or permanent unconscious condition, [*Choose one*]

I want _____ do not want _____

artificially administered nutrition and hydration to be withdrawn or withheld the same as other forms of life-sustaining treatment. I understand artificially administered nutrition and hydration is a form of life-sustaining treatment in certain circumstances. I request all health care providers who care for me to honor this directive.

(D) In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this directive shall be honored by my family, physicians and other health care providers as the final expression of my fundamental right to refuse medical or surgical treatment, and also honored by any person appointed to make these decisions for me, whether by durable power of attorney or otherwise. I accept the consequences of such refusal.

(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 competent to make this directive. I also understand that I may amend or revoke this directive at any time.

(G) I make the following additional directions regarding my care:

_____

_____

_____

_____

Signed: _____

The declarer has been personally known to me and I believe him or her to be of sound mind. In addition, I am not the attending physician, an employee of the attending physician or health care facility in which the declarer is a patient, or any person who has a claim against any portion of the estate of the declarer upon the declarer's decease at the time of the execution of the directive.

Witness: _____

Witness: _____

了解更多信息

这些表格由华盛顿州医学会提供为公共服务。我们鼓励您与您的医生讨论醫療指示。律师可以回答你的醫療指示的使用和效果提出的任何法律问题 。

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ICHS VISION CLINIC
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Seattle, WA 98104
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ICHS LEGACY HOUSE
803 S Lane St
Seattle, WA 98104
TEL 206.292.5184

HOLLY PARK MEDICAL & DENTAL CLINIC
3815 S Othello Street
Seattle, WA 98118
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BELLEVUE MEDICAL & DENTAL CLINIC
1050 140th Ave NE
Bellevue, WA 98005
TEL 425.373.3000

SHORELINE MEDICAL & DENTAL CLINIC
16549 Aurora Ave N
Shoreline, WA 98133
TEL 206.533.2600

ICHS MEAL PROGRAM AT BUSH ASIA CENTER
409 Maynard Ave S, Plaza 6
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TEL 206.521.4129

SEATTLE WORLD SCHOOL TEEN HEALTH CENTER
1700 E Union St
Seattle, WA 98122
TEL 206.332.7160

HIGHLAND MIDDLE SCHOOL HEALTH CENTER
TEL 425.456.6453

ICHS PRIMARY CARE CLINIC AT ACRS
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MOBILE DENTAL CLINIC
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