

Advance Directives



Information About Advance Directives

Have you thought about what kind of health care you would want to receive if you became very ill or hurt? If you were no longer able to express your wishes, would your doctor and family know what you would want?

This booklet was designed to help you think about these questions. Washington state law supports your right to make decisions about your health care. You can express your decisions about the kind of care you wish to receive through Advance Directives.

What Are Advance Directives?

Formal Advance Directives are papers written before a serious illness that state your choices for health care (Physician Orders for Life Sustaining Treatment, also known as POLST) or name someone to make those choices (Durable Power of Attorney for Health Care), if you become unable to make decisions. Through Advance Directives, you can make legally valid decisions about your future medical care. This booklet provides information about preparing the Physician Orders for Life Sustaining Treatment and a Durable Power of Attorney for Health Care forms.

Are Advance Directives Legal?

Yes. There are federal and state laws that govern the use of Advance Directives. All 50 states and the District of Columbia have laws recognizing the use of advance directives. If you travel, you may want to take copies of your documents with you, as other states may honor these forms.

Will Advance Directives Be Recognized in Emergencies?

No. During most emergencies, there is not enough time for emergency service personnel to consult the patient's Advance Directive. Once the patient is under the direct care of a physician, there will be time for the Advance Directive to be evaluated and/or the health care agent to be consulted.

What Are Physician Orders for Life Sustaining Treatment?

The Physician Orders for Life-Sustaining Treatment (**POLST**) is a form that documents a physician order summarizing your wishes regarding life-sustaining treatment. The form accomplishes two major purposes:

- It is portable from one care setting to another.
- It translates wishes of an individual into actual physician orders.

The POLST form facilitates the process of translating end-of-life discussions with patients into actual treatment decisions, and provides security for the individual and physician that the expressed wishes will be carried out. There is no other form that streamlines the process in this way.

A copy of the POLST is provided for you on Page 6.

What if I Don't Have a POLST?

The decision to have written directives is a personal one. The best way to make your wishes known is to put them in writing. Some people find it comforting to have written directives. They feel it eases the load of decision making for family and friends.

Can I Change My POLST?

Yes, you may change or cancel a POLST at any time. You may do this by destroying the document, putting your change in writing, or telling your doctor, nurse and family about the change. If you change your POLST, you should give new copies to your family, doctor, lawyer or others who may be involved. Your doctor must know about the change or it will not be effective.

What Are Life-Sustaining Treatments?

There are several life-sustaining treatments and medical interventions that can lengthen a person's life, delaying the moment of death. We would like you to consider these and discuss your choices with your family, friends and doctor. It is important your wishes be known in case you are unable to speak for yourself.

Life-sustaining treatments do not include procedures or medicine given to relieve pain. Surgery also poses exceptions to Advance Directives that you should discuss with your physician. A decision to forego life-sustaining treatment will in no way affect the care you are given to provide comfort and reduce pain. *Supportive care given for comfort and pain relief will always be provided.* The following are some life-sustaining treatments:

- *Cardiopulmonary Resuscitation (CPR)*

CPR is used when a person's heart or lungs have suddenly stopped working. It usually involves chest compressions, the use of drugs and/or electric shock to restore the heartbeat, and the placement of a tube in the windpipe to maintain breathing. CPR may not be appropriate for certain patients (such as those in the process of dying due to terminal illness, those in a persistent vegetative state, or those with an incurable illness) as its use would only lengthen the process of dying.

- *Respirator/Ventilator*

A respirator/ventilator is a machine that, by moving air into the lungs, breathes for a person who is unable to breathe naturally. Ventilators are sometimes used after a person has had surgery or when a person has an illness. The ventilator helps the person to breathe until he or she is able to do so on their own. A ventilator may not be appropriate for a patient with a terminal illness, however, because the use of a ventilator may only prolong the process of dying.

- *Artificial Nutrition and Hydration*

Artificial nutrition and hydration are ways to provide food or fluids to a person who is unable to eat or drink. Food and/or fluids can be given directly or indirectly into the stomach (also called "tube feeding") or through an intravenous line. These methods are commonly used when there is a temporary loss of eating or digestive function. When death is certain or there is no hope for recovery, the use of artificial food and fluids may only prolong the process of dying.

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 <hr/> Date of Birth Last 4 #SSN (optional) <hr/>	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	Check One	CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing. When not in cardiopulmonary arrest, go to part B. <input type="checkbox"/> Attempt Resuscitation/CPR <input type="checkbox"/> Do Not Attempt Resuscitation/DNAR (Allow Natural Death) Choosing DNAR will include appropriate comfort measures.								
B	Check One	MEDICAL INTERVENTIONS: Person has pulse and/or is breathing. <input type="checkbox"/> 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. <input type="checkbox"/> 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. <input type="checkbox"/> 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: <u>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.</u>									
Discussed with: <input type="checkbox"/> Patient <input type="checkbox"/> Parent of Minor <input type="checkbox"/> Guardian with Health Care Authority <input type="checkbox"/> Spouse/Other as authorized by RCW 7.70.065 <input type="checkbox"/> Health Care Agent (DPOAHC)		<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%; border-bottom: 1px solid black; padding: 2px;"><u>PRINT</u> — Physician/ARNP/PA-C Name</td> <td style="width: 40%; border-bottom: 1px solid black; padding: 2px;">Phone Number</td> </tr> <tr> <td style="border-bottom: 1px solid black; padding: 2px;"><input checked="" type="checkbox"/> Physician/ARNP/PA-C Signature (mandatory)</td> <td style="border-bottom: 1px solid black; padding: 2px;">Date (mandatory)</td> </tr> <tr> <td style="border-bottom: 1px solid black; padding: 2px;"><u>PRINT</u> — Patient or Legal Surrogate Name</td> <td style="border-bottom: 1px solid black; padding: 2px;">Phone Number</td> </tr> <tr> <td style="border-bottom: 1px solid black; padding: 2px;"><input checked="" type="checkbox"/> Patient or Legal Surrogate Signature (mandatory)</td> <td style="border-bottom: 1px solid black; padding: 2px;">Date (mandatory)</td> </tr> </table>	<u>PRINT</u> — Physician/ARNP/PA-C Name	Phone Number	<input checked="" type="checkbox"/> Physician/ARNP/PA-C Signature (mandatory)	Date (mandatory)	<u>PRINT</u> — Patient or Legal Surrogate Name	Phone Number	<input checked="" type="checkbox"/> Patient or Legal Surrogate Signature (mandatory)	Date (mandatory)
<u>PRINT</u> — Physician/ARNP/PA-C Name	Phone Number									
<input checked="" type="checkbox"/> Physician/ARNP/PA-C Signature (mandatory)	Date (mandatory)									
<u>PRINT</u> — Patient or Legal Surrogate Name	Phone Number									
<input checked="" type="checkbox"/> Patient or Legal Surrogate Signature (mandatory)	Date (mandatory)									
Person has: <input type="checkbox"/> Health Care Directive (living will) <input type="checkbox"/> 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.



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.)

X Physician/ARNP/PA-C Signature	Date
X 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 interventions, 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
			<input type="checkbox"/> No Change <input type="checkbox"/> Form Voided <input type="checkbox"/> New form completed
			<input type="checkbox"/> No Change <input type="checkbox"/> Form Voided <input type="checkbox"/> 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.
 For more information on POLST visit www.wsma.org/polst.

OVER ►

Organ and Tissue Donation

If you wish to be an organ and/or tissue donor, you can state this desire in your health care directive. You can register with the region's federally-designated organ donation organization, LifeCenter Northwest Organ Donation Network, at www.lcnw.org or 1-877-275-5269. You can also register as a donor at the Department of Motor Vehicles when you apply for or renew your driver's license.

A symbol of your donor status will appear on your license. Registration means you have chosen to have the organs and tissues you designate made available for transplant, research or both, to help others at the time of your death. If you are registered as a donor, no further consent is needed to move forward with donation.

Whether or not you are a donor, it is important to talk to your family about your decision. With no directive or registry record, your family may be asked to make a decision on your behalf. To ensure your wishes are carried out, it is important to clearly share your decision with your family, so they can support it at the time of death.

Who Makes Health Care Decisions for Me If I Can't?

Washington state law sets the following order of priority for people to make decisions on your behalf if you cannot make decisions for yourself:

1. Your guardian, if one has been appointed
2. The person named in your Durable Power of Attorney for Health Care
3. Your spouse/registered domestic partner
4. Your adult children
5. Your parents
6. Your adult brothers and/or sisters

The person chosen to make decisions on your behalf is responsible by state law to follow your wishes as stated in your directives.

What is a Durable Power of Attorney for Health Care?

A Durable Power of Attorney for Health Care is a paper in which you name another person to make medical decisions for you anytime you are unable to make them for yourself. You can include instructions about any treatment you want or do not want, such as surgery, artificial nutrition and hydration (such as fluids or medicine). You can draw up a Durable Power of Attorney for Health Care with or without the advice of a lawyer. Your representative should understand and respect your health care wishes.

How Do I Prepare a Durable Power of Attorney for Health Care?

1. Review the Durable Power of Attorney for Health Care form located on the next page. Think about whether you wish to change the form and any special instructions you wish to include to limit or guide your representative. Write or type these instructions and attach them to the form.
2. Select the person who you want to act as your representative. Obtain his or her consent to be your Durable Power of Attorney for Health Care. Tell him or her as directly as possible the kinds of decisions you want made on your behalf.
3. Sign and date the form with two eligible witness signatures or with notary .
4. Make copies of your Durable Power of Attorney for Health Care for yourself, your representative, close family members and your lawyer, if you have one. Give your original Durable Power of Attorney for Health Care to your doctor. The Durable Power of Attorney for Health Care needs to be in the medical record kept by your doctor to ensure your wishes are followed.

Can I Change My Durable Power of Attorney for Health Care?

Yes, you may change or cancel a Durable Power of Attorney for Health Care at any time. You may do this by destroying the document, putting your change in writing, or telling your doctor, nurse and family about the change. If you change your Durable Power of Attorney for Health Care, you should give new copies to your family, doctor, lawyer, or others who may be involved.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

Notice to Person Executing This Document

This is an important legal document. Before executing this document you should know these facts:

- This document gives the person you designate as your Health Care Agent the power to make MOST health care decisions for you if you lose the capability to make informed health care decisions for yourself. This power is effective only when you lose the capacity to make informed health care decisions for yourself. As long as you have the capacity to make informed health care decisions for yourself, you retain the right to make all medical and other health care decisions.
- Your Health Care Agent should be someone you trust to make health care decisions on your behalf. Your Health Care Agent may be any adult, including relatives such as your spouse, state registered domestic partner, father, mother, adult child, or adult brother or sister. Unless they are one of the relatives listed above, your Health Care Agent may not be any of your physicians or your physicians' employees, or the owners, administrators or employees of a health care facility or long-term facility (as defined by RCW 43.190.020) where you reside or receive care.
- You may include specific limitations in this document on the authority of the Health Care Agent to make health care decisions for you.
- Subject to any specific limitations you include in this document, if you do lose the capacity to make an informed decision on a health care matter, the Health Care Agent *GENERALLY* will be authorized by this document to make health care decisions for you to the same extent as you could make those decisions yourself, if you had the capacity to do so. The authority of the Health Care Agent to make health care decisions for you *GENERALLY* will include the authority to give informed consent, to refuse to give informed consent, or to withdraw informed consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical condition. You can limit that right in this document.
- When exercising authority to make health care decisions for you on your behalf, the Health Care Agent will have to act consistent with your wishes, or if they are unknown, in your best interest. You may make your wishes known to the Health Care Agent by including them in this document or in another manner.
- When acting under this document the Health Care Agent *GENERALLY* will have the same rights that you have to receive information about proposed health care, to review health care records, and to consent to the disclosure of health care records.

1. Creation of Durable Power of Attorney for Health Care

I intend to create a power of attorney (Health Care Agent) by appointing the person or persons designated herein to make health care decisions for me to the same extent that I could make such decisions for myself if I was capable of doing so, as recognized by Washington law. This power of attorney shall become effective when I become disabled and I cannot make health care decisions for myself as determined by my attending physician or designee, such as if I am unconscious, or if I am otherwise temporarily or permanently incapable of making health care decisions. The Health Care Agent's power shall cease if and when I regain my capacity to make health care decisions.

2. Designation of Health Care Agent and Alternate Agents

If my attending physician or his or her designee determines that I am not capable of giving informed consent to health care, I _____, designate and appoint:

Name _____ Address _____

City _____ State _____ Zip _____ Phone _____

as my attorney-in-fact (Health Care Agent) by granting him or her the Durable Power of Attorney for Health Care recognized in Washington law and authorize her or him to consult with my physicians about the possibility of my regaining the capacity to make treatment decisions and to accept, plan, stop, and refuse treatment on my behalf with the treating physicians and health personnel.

In the event that _____ is unable or unwilling to serve, I grant these powers to

Name _____ Address _____

City _____ State _____ Zip _____ Phone _____

In the event that both _____ and _____ are unable or unwilling to serve, I grant these powers to

Name _____ Address _____

City _____ State _____ Zip _____ Phone _____

3. General Statement of Authority Granted.

My Health Care Agent is specifically authorized to give informed consent for health care treatment when I am not capable of doing so. This includes but is not limited to consent to initiate, continue, discontinue, or forgo medical care and treatment including artificially supplied nutrition and hydration, following and interpreting my instructions for the provision, withholding, or withdrawing of life-sustaining treatment, which are contained in any Health Care Directive or other form of "living will" I may have executed or elsewhere, and to receive and consent to the release of medical information. When the Health Care Agent does not have any stated desires or instructions from me to follow, he or she shall act in my best interest in making health care decisions.

The above 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 Chapter 71.05 RCW;
- (4) Sterilization.

I hereby revoke any prior grants of durable power of attorney for health care.

4. Special Provisions

DATED this _____ day of _____, _____
(Year)

GRANTOR: _____ GRANTOR'S SIGNATURE _____

NOTE: Washington state requires this directive to be notarized or witnessed by two different witnesses.

WITNESS _____ WITNESS _____

WITNESS REQUIREMENTS: The witnesses to this document must be competent and must NOT be:

- Home care providers for the individual completing this document;
- Care providers at an adult family home or long-term care facility if you live there; or
- Related to you or the designated Health Care Agent by blood, marriage, or state registered domestic partnership.

STATE OF WASHINGTON

(COUNTY OF _____)

I certify that I know or have satisfactory evidence that the GRANTOR, _____
signed this instrument and acknowledged it to be his or her free and voluntary act for the uses and purposes mentioned in the instrument.

DATED this _____ day of _____, _____
(Year)

NOTARY PUBLIC in and for the State of Washington,
residing at _____
Printed name _____
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: _____

For Further Information

These forms have been provided as a public service by the Washington State Medical Association. You are encouraged to discuss the directives with your physician. Any legal questions you may have about the use and effect of directives may be answered by an attorney.



ADMINISTRATION

720 8th Ave S, 2nd Floor
Seattle, WA 98104
TEL 206.788.3650
TTY 206.788.3774

MAILING ADDRESS

PO Box 3007
Seattle, WA 98114-3007

INTERNATIONAL DISTRICT MEDICAL, DENTAL & VISION CLINIC

720 8th Ave S
Seattle, WA 98104
TEL 206.788.3700

MOBILE DENTAL CLINIC

TEL 206.445.8454

HOLLY PARK MEDICAL & DENTAL CLINIC

3815 S Othello Street
Seattle, WA 98118
TEL 206.788.3500

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

SEATTLE WORLD SCHOOL TEEN HEALTH CENTER

1700 E Union St,
Seattle, WA 98122
TEL 206.332.7160

HIGHLAND MIDDLE SCHOOL HEALTH CENTER

15027 NE Bel-Red Rd
Bellevue, WA 98007
TEL 425.456.6453

ICHS PRIMARY CARE CLINIC AT ACRS

3639 Martin Luther King Jr Way S
Seattle, WA 98144
TEL 206.695.7600

ATTENTION:

** ICHS does not discriminate on the basis of race, color, sex, marital status, sexual orientation, political ideology, age, creed, religion, ancestry, gender identity, genetic information, use of service animals, national origin, veteran status, citizenship status, or the presence of any sensory, mental or physical disability, veterans with disabilities and Vietnam era veterans in accordance with federal, state and local laws and regulations.*

** If you have questions or concerns about your rights, please contact the ICHS Compliance Hotline at 1-855-515-0143.*

** Language assistance services are available to you free of charge. Call 1-855-515-0143 (TTY: 1-206-788-3774).*