Advance Directive WASHINGTON

This advance directive and designation of a health care representative (durable power of attorney for health care) is in compliance with applicable sections of Washington's Natural Death Act (Revised Code of Washington Chapter 70.122) and Uniform Power of Attorney Act (Revised Code of Washington Chapter 11.125), and the Revised Code of Washington Chapter 71.32.

Print your name (Individual): _____

Address: _____

This Advance Directive belongs to the person named above, who is the "Individual."

Step 1: Name your health care representative

This health care representative (durable power of attorney for health care) will be able to make decisions for me if I am unable to make my own decisions.

1. I want this person to make my health care decisions:

Name: _____ Relationship: _____ Cell phone:_____

Work phone: _____ Home phone: _____ Email: _____

Address: _____

If the above person cannot make my health care decisions, then I want this person to do so:

Name: _____ Relationship: _____ Cell phone:_____

Work phone: _____ Home phone: _____ Email: _____

Address: _____

If the two persons listed above cannot make my health care decisions, then I want this person to do so:

Name: _____ Relationship: _____ Cell phone:_____

Work phone: _____ Home phone: _____ Email: _____

Address: _____

2. Put an X next to the ONE sentence you agree with:

☐ My health care representative will make decisions for me **ONLY** during times I am unable to make my own decisions.

☐ My health care representative can make decisions for me right now, after I sign this form.

Individual (print name): _____ **Date of birth:** _____

3. **How do you want your health care representative to follow your health care wishes?**

   Put an X next to the **ONE** sentence you most agree with:

   ☐ **Total flexibility:** It is OK for my health care representative NOT to follow **any** of my health care wishes if, after talking with my doctors, he/she thinks it is best for me at that time.

   ☐ **Some flexibility:** It is OK for my health care representative NOT to follow **some** of my health care wishes if, after talking with my doctors, he/she thinks it is best for me at that time.

   ☐ **Minimal flexibility:** I want my health care representative to follow my health care wishes as closely as possible. Please respect my wishes, even if doctors recommend otherwise.

Step 2: Indicate your health care wishes.

1. **My life is (put an X by your choice of A or B):**

   ☐ A. Always worth living no matter how sick I am

   ☐ B. Only worth living if (put an X by all that are true for you):

   - ☐ I can talk with family and friends
   - ☐ I can wake up from a coma
   - ☐ I can feed, bathe or take care of myself
   - ☐ I can be free from pain
   - ☐ I can live without being hooked up to machines
   - ☐ I am not sure what particular circumstances would make my life worth living
   - ☐ In my own words:

2. **If I am so sick that I will likely die soon (put an X by the one you choose):**

   See supplemental materials for more information on life support treatments.

   ☐ Try all life-support treatments that my doctors think might help. If the treatments do not work and there is little hope of getting better, **I want to stay on life-support machines** even if I may be suffering.

   ☐ Try all life-support treatments that my doctors think might help. If the treatments do not work and there is little hope of getting better, **I DO NOT want to stay on life-support machines.** If I am suffering, I want life-support treatments to stop so that I can be allowed to die gently.

   ☐ **I DO NOT want life-support treatments.** I want to focus on being comfortable. I prefer to have a natural death.

   ☐ I want my **health care representative** to decide for me.

   ☐ I am not sure what I would like done.

Individual (print name): _____ **Date of birth:** _____

3. **If I am dying, it is important for me to be (put an X by the one you choose):**

- ☐ At my home or the home of a loved one
- ☐ In a hospital or other care center
- ☐ Any place where I can be cared for in comfort and ease both for myself and my loved ones
- ☐ Other wishes about places where I want to be or not be:

- ☐ – OR – It is not important to me where I am cared for

4. **Here is more information to help my health care representative know of my wishes and preferences:**

I am comforted by (types of music, readings, presence of certain people or pets, massage, etc.):

These cultural, spiritual or religious beliefs and practices are important to me:

I would like to donate the following organs or tissues when I die (if any):

I have the following funeral arrangements and would like to be (buried, cremated, etc. ...
Include information about any specific death rituals or practices):

If anyone asks how I want to be remembered, please say this about me:

Other things I want you to know:

Consider attaching an extra page with a list of individuals you would like contacted to let them know of your health condition. Include names and contact information. Be sure to include your name and date of birth.

Individual (print name): _____ **Date of birth:** _____

Step 3: Sign document in front of either 1) two witnesses or 2) notary public

Individual's signature: _____ **Date:**_____

1. Option 1 – TWO Witnesses

By signing as a witness, I (the witness) affirm that I meet the following requirements:

- I was present when the Individual signed this form
- I know the Individual is who he/she says he/she is
- I am at least 18 years old
- The Individual does not appear to be incapacitated or acting under fraud, undue influence or duress
- I am not the Individual's health care representative
- I am not the Individual's health care provider
- I am not an employee of the Individual's health care provider
- I am not a care provider where the Individual lives
- I am not related to the Individual by blood, marriage or domestic partnership
- I will not benefit financially — be eligible for any of the Individual's money or property — after the Individual dies

Signature:_____ Date: _____

Name:_____

Address: _____

_____

_____

_____

Signature:_____ Date: _____

Name:_____

Address: _____

_____

_____

_____

2. Option 2 – Notary

State of Washington
County of_____

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

(Notary Seal)

Dated: _____

Signature of Notary Public: _____

Title:_____

My appointment expires: _____

Step 4: Be sure to give copies of your completed advance directive to your health care representative and alternates, health care providers, family members, friends and others important to you.

Individual (print name): _____ **Date of birth:** _____

Instructions and information

Step 1:
Name your health care representative

1. Name someone you trust to make health care choices for you if you are unable to make your own decisions. Provide name and contact information for this person, along with one or two additional individuals.

   Choose a family member or friend who:

   - Is 18 years of age or older
   - Knows you well
   - Is willing to do this for you
   - Is able to make difficult decisions based on your wishes
   - Will effectively communicate the information you provide in your advance directive to health care providers and family members
   - Will have an ongoing conversation with you about your health and your wishes

   *Your representative **cannot** be your doctor or someone who works at the hospital or clinic where you are receiving care unless he or she is a member of your family.*

   Your health care representative can:

   - Decide where you will receive care
   - Select or dismiss health care providers
   - Agree to or say no to medications, tests and treatments, including those for life support
   - Take legal action needed to carry out your wishes
   - Contact a spiritual leader or others on your behalf
   - Help you receive health care consistent with your wishes
   - Help with decisions about what happens to your body and organs after you die (however, note that your health care representative's legal decision-making authority ends when you die, so be as clear as you can in your advance directive about issues important to you and plan accordingly).

2. In most cases, individuals want their health care representative to make decisions for them only during times they are unable to make their own decisions; however, you might want that help immediately. Remember that as long as you have the ability to make your own decisions and can communicate, you can update your advance directive.

3. Select one of the choices concerning flexibility to provide guidance for your health care representative.

Step 2:
Indicate your health care wishes

1. Choose A or B. If you choose B, it will be helpful to your health care representative to know more by selecting the items true for you and adding information important to you.

2. Select one of the choices to provide guidance concerning life support treatments. Below is some information about some life support treatments that may or may not be successful in helping you live longer. Ask your health care providers for more information as needed.

   CPR or cardiopulmonary resuscitation
   This may involve (1) Pressing hard on your chest to keep your blood pumping, (2) Electrical shocks to jump-start your heart, (3) Medicines in your veins.

   Breathing machine or ventilator
   This machine pumps air into your lungs and breathes for you through a tube placed in your throat. You are not normally able to talk or eat when you are on the machine.

   Dialysis
   This machine cleans your blood if your kidneys stop working.

Instructions and information

Feeding tube
This tube provides food to your body if you cannot swallow. The tube is placed down your throat into your stomach. It can also be placed surgically through your abdomen.

Blood transfusions
This puts your (or another person's) blood into your veins.

Other life support treatments might include surgery and medicines.

3 Select one of the choices to provide guidance to your health care representative.

4. Provide information you want others to know in order to help your wishes be honored, such as
   - Religious or spiritual beliefs, including spiritual leaders you want contacted if you might die soon
   - Your wishes in terms of organ or tissue donation
   - Whether you would prefer to have an autopsy or not
   - Your preference about burial or cremation
   - Information about other durable power of attorney documents, such as for finances or mental capacity
   - More details about decisions you want or do not want your health care representative to make

Note: *You can add extra pages to your Advance Directive as needed to capture what is important for others to know. If you add pages, clearly label as additions to your Advance Directive and include your name, signature and date of birth on each page. You can also omit or strike through items you decide not to complete.*

Step 3:
Sign document in front of either 1) two witnesses or 2) notary public.

Step 4:
Give copies of your completed advance directive (pages 1-4 plus extra pages) to:

- Health care representative (and alternates)
- Family
- Friends
- Attorney (if you have one)
- Health care providers
- Hospitals
- Clergy, rabbi, imam or faith community representative (if appropriate for you)

Keep a list of where you send your advance directive so that you can replace with updates whenever you change your designated health care representative or alternates, or your health care wishes.

Store your advance directive so it can be easily found in an emergency. Consider keeping a PDF copy on your phone app or on an electronic storage device (USB), copies in your glove compartment, etc. Make it easy for your family members and friends to find your documents.

You might choose to keep the instruction pages with your Advance Directive; however, the copies you share just need to be the four-page Advance Directive form plus any extra pages you add.

Instructions and information

Notice of nondiscrimination and accessibility rights

We comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. Swedish does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. Swedish:

(1) Provides free aids and services to people with disabilities to communicate effectively with us, such as: (a) Qualified sign language interpreters; and (b) Written information in other formats (large print, audio, accessible electronic formats, other formats).

(2) Provides free language services to people whose primary language is not English, such as: (a) Qualified interpreters; and (b) Information written in other languages.

If you need any of the above services, please contact the appropriate civil rights coordinator below. If you need Telecommunications Relay Services, please call 1-800-833-6384 or 7-1-1.

If you believe that Swedish has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Swedish by contacting the civil rights coordinator for your service location as listed below:

Service location	Civil rights coordinator
All locations except Swedish Edmonds	Civil rights coordinator, 101 W. 8th Ave., Spokane, WA 99204 Telephone: 1-844-469-1775; Interpreter line: 1-888-311-9127 Email: Nondiscrimination.WA@providence.org
Swedish Edmonds	Civil rights coordinator (Bed Control), 21601 76th Ave. W. Edmonds, WA 98026 Telephone: 1-844-469-1775; Interpreter line: 1-888-311-9178 Email: Nondiscrimation.SHS@providence.org
Senior Services	Civil rights coordinator, 2811 S. 102nd St., Suite 220, Tukwila, WA 98168 Telephone: 1-844-469-1775; Interpreter line: 1-888-311-9127; Email: Nondiscrimination.pscs@providence.org

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, one of the above-noted civil rights coordinators is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Ave. SW
Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Instructions and information

We do not discriminate on the basis of race, color, national origin, sex, age, or disability in our health programs and activities.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 888-311-9127 (Swedish Edmonds 888-311-9178) (TTY: 711).

注意：如果您講中文，我們可以給您提供免費中 文翻譯服務，請致電 888-311-9127 (Swedish Edmonds 888-311-9178) (TTY: 711)

CHÚ Ý: Nếu bạn nói Tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn dành cho bạn. Gọi số 888-311-9127 (Swedish Edmonds 888-311-9178) (TTY: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 888-311-9127 (Swedish Edmonds 888-311-9178) (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 888-311-9127 (Swedish Edmonds 888-311-9178) (TTY: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 888-311-9127 (Swedish Edmonds 888-311-9178) (телетайп: 711).

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Եթե խոսում եք հայերեն, ապա ձեզ կարող են տրամադրվել լեզվական աջակցության անվճար ծառայություններ: Զանգահարեք 888-311-9127 (Swedish Edmonds 888-311-9178) (հեռատիպ (TTY)՝ 711).

يُرجى الانتباه: إذا كنتم تتكلمون اللغة العربية، فأعلموا أن خدمات المساعدة اللغوية متوفرة مجاناً لكم. اتصلوا برقم الهاتف 888-311-9127 [أو برقم الهاتف 888-311-9178 عند الاتصال بالمركز الطبي السويدي في إدموندز (Swedish Edmonds)] (أو بخط المبرقة الكاتبة TTY لضعاف السمع والنطق على الرقم 711).

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با شماره 888-311-9127 (Swedish Edmonds 888-311-9178) (TTY:711) تماس بگیرید.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます. 888-311-9127 (Swedish Edmonds 888-311-9178) (TTY:711) まで、お電話にてご連絡ください.

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਿ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਧਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਿ ਹੈ। 888-311-9127 (Swedish Edmonds 888-311-9178) (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

សូមចាំអារម្មណ៍៖ ប្រសិនបើលោកអ្នកនិយាយភា សាខ្មែរ នោះសេវាជំនួយផ្នែកភាសានឹងមានផ្តល់ជូន លោកអ្នក ដោយឥតគិតថ្លៃ។ សូមទូរស័ព្ទទៅលេខ 888-311-9127 (Swedish Edmonds 888-311-9178) (TTY: 711)។

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 888-311-9127 (Swedish Edmonds 888-311-9178) (TTY: 711) पर कॉल करें।

LUS CEEV: Yog tias koj hais lus Hmoob, koj tuaj yeem siv cov kev pab txhais lus pub dawb. Hu rau 888-311-9127 (Swedish Edmonds 888-311-9178) (TTY: 711).

โปรดทราบ: หากคุณพูดภาษาไทย คุณสามารถใช้บริ การความช่วยเหลือทางภาษาได้โดยไม่มีค่าใช้จ่าย โทร 888-311-9127 (Swedish Edmonds 888-311-9178) (TTY: 711)

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If you have questions related to completing or returning your advance directive, please contact your local health care providers. You can also find additional information at:

https://www.swedish.org/patient-visitor-info/patient-information/preparing-for-your-hospital-stay/advance-directives

Providence.org/InstituteForHumanCaring

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