PERSONAL STATEMENT OF: _____

Since I cannot know how a terminal illness will develop, the requests I make now for end-of-life care cannot be specific to my condition if I am dying and cannot speak for myself. I am writing the following statement of my values and perspective to guide you as you make decisions about my end-of-life care consistent with my wishes to manage situations not addressed in my Advance Directive.

Your Signature: _____ **Date:** _____

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Step 3 Create an Advance Directive

By signing and having witnesses sign the document below, you will complete your Advance Directive.

ADVANCE DIRECTIVE TO PHYSICIANS

Declaration made this _____ day of _____ (month), 20 _____

I, (PRINT NAME) _____ , having the capacity to make healthcare decisions, willfully and voluntarily make known my wishes for my end-of-life care.

1. I reserve the right to make decisions about the care I receive as long as I retain the capacity to do so.

2. As an overview of my beliefs, I choose either "2a" OR "2b" as my belief, (not both).

   2a. I believe that life is worth living regardless of its quality and I request that I be given all possible treatments to prolong my life, regardless of their expected effects and their physical, psychological, and/or economic impact.

   _____ This is my belief (initial).
   If 2(a) is your belief, draw an "X" over Item 3 and skip to Item 4.

   2b. If my condition reaches a point that I regard as worse than death, I want palliative care to manage my pain, make me as comfortable as possible, and allow me to preserve my dignity with no effort made to prolong my life.

   _____ This is my belief (initial).
   If 2(b) is your belief, draw an "X" over Item 2a and please continue to Item 3.

3. **Since I endorsed #2b,** I want it known that I consider any condition or combination of conditions checked below to be a state that I consider to be worse than death ***if they cannot be controlled and have little to no chance of being reversed***. (Initial all that apply).

   a. _____ I am unconscious with little to no chance of ever regaining consciousness, that is, if I am in a "permanent vegetative state."

   b. _____ I have permanent uncontrollable pain that makes it difficult for me to pay attention to anything else.

   c. _____ I cannot breathe unless I am on a ventilator.

   d. _____ I cannot take in food or water other than by tube.

   e. _____ I cannot remember who or where I am and cannot recognize my family or friends.

   f. _____ I cannot control my destructive or anti-social behavior, putting myself or others at risk of serious injury.

   g. _____ Other: _____

   _____

4. As a **general guide**, when I am suffering with a terminal illness that could end my life, I would like the following scope of treatment: (Initial ONE)

   _____**Full aggressive or curative treatment to externally prolong life.** This includes any treatment recommended by my doctors to manage my condition and control my pain and discomfort. This may include any drug, surgical procedure, life support measures such as CPR, shocks to restart my heart, food, and water by tube (e.g. PEG), mechanical ventilator to aid breathing, and body wastes drained by tube. I understand that I may be unable to live without mechanical support prior to death.

   _____**Limited use of invasive measures and avoidance of aggressive procedures.** This may include use of drugs and other methods to control my illness, infection and/or pain, IV fluids but not via PEG, body drains; breathing assistance via CPAP or BiPAP machine, minor surgery, and/or use of CPR or shocks only if my heart stopped due to a temporary reversible event. I understand this is likely to delay my dying and that I can decide how long I want to use limited treatment before switching to comfort care only.

   _____**Comfort care only, allowing natural death.** This includes the use of drugs only to treat pain and psychological discomfort, other procedures such as positioning and wound care, procedures to ease my breathing, including oxygen, oral suctioning, and manual methods to clear my airways, but NO surgery, CPR, shocks, ventilators, tubes for food or water, or other aggressive measures. I understand that because I am refusing aggressive procedures, I may die sooner.

5. Cardiopulmonary Resuscitation (CPR). Initial ONE:

_____ **AACPR** Always DO attempt to resuscitate (CPR) any time my heart stops beating.

_____ **DNAR-X** DO resuscitate only if my heart stopped or breathing due to a temporary reversible event, e.g. anaphylactic shock or medical error, etc.

_____ **DNAR** DO NOT resuscitate or use defibrillator under any circumstance. Always allow natural death.

6. Added requests. If I am in a condition that I consider **worse than death**, I do/do not want the following procedures, with qualifications indicated:

Procedure		If yes, conditions including duration in days of any trials
a. Defibrillation (shocks to heart)	___Yes ___No	
b. Mechanical respiration (ventilator)	___Yes ___No	
c. Nutrition by surgically inserted tube	___Yes ___No	
d. Fluids by surgically inserted tube	___Yes ___No	
e. Kidney dialysis	___Yes ___No	
f. Pacemaker or other mechanical device	___Yes ___No	
g. If I already have a pacemaker or other inserted device, I would like it turned off.	___Yes ___No	
h. Transfer to hospital: _____Whenever suggested. _____Only for brief management of treatable problem. _____ Only if essential to relieve pain/discomfort.		
i. Other: _____ _____		

7. To clarify my wishes by examples, I would want the treatment indicated if I experience any of the conditions described below,

My Condition	The Level of Treatment I would Like
If I have lost consciousness with no hope of becoming conscious again, e.g. if I am in a "permanent vegetative state" and I have a terminal illness or injury that cannot be reversed and will get worse no matter what treatment I undergo, I wish to receive...:	CHOOSE ONE _____ Full Aggressive Treatment _____ Limited Treatment _____ Comfort Care Only
If I am conscious and I am experiencing permanent pain so intense that I can barely think of anything else, and I have a terminal illness that cannot be reversed and will get worse no matter what treatment I undergo, I wish to receive...:	CHOOSE ONE _____ Full Aggressive Treatment _____ Limited Treatment _____ Comfort Care Only
If I lose my identity because I cannot think or communicate clearly due to an incapacitating stroke, aneurysm, or some form of progressive permanent, and I have a terminal illness that cannot be reversed and will get worse no matter what treatment I undergo. I wish to receive...:	CHOOSE ONE _____ Full Aggressive Treatment _____ Limited Treatment _____ Comfort Care Only
If it is impossible for me to control my breathing, movement, or other bodily functions because I have an advanced stage of a severe irreversible progressive disease with symptoms such as those of ALS or "Locked in Syndrome" and my condition will get worse no matter what treatment I undergo, I wish to receive...:	CHOOSE ONE _____ Full Aggressive Treatment _____ Limited Treatment _____ Comfort Care Only

8. I have stated my requests as clearly as I can at this time. Realizing that I may not have anticipated all possible details about the illness and/or infirmity that I may suffer, I ask that my providers and Healthcare Representative base decisions about aspects of my care that are not covered in my Advance Directive on my values and beliefs as expressed in my attached Personal Statement dated _____ and after consulting with others named in my Durable Power of Attorney for Healthcare.

9. To the extent that it is possible, I prefer to die (Please indicate 1st, 2nd, and 3rd choice):

   _____ At home, with-in home hospice care if necessary. _____ In a hospice. _____ In a nursing home or a hospital.

10. If it is permitted in the jurisdiction in which I am terminally ill, and if I request this service, and if I meet the requirements for the procedure, (*Please initial ONE*) _____ I DO _____ I DO NOT want to be considered for medical aid in dying (MAID).

11. Upon my death, regarding organ donation (*Please initial ONE*):

    _____ I wish to leave this decision to my Healthcare Representative.

    _____ I DO NOT want to donate any part of my body.

    _____ I DO want to donate all organs, tissues, or body parts that are useful.

    _____ I DO want to donate only the following organs, tissues or body parts:

    _____

    If any part of my body is taken I agree that these donations can be used for (*Initial all that apply)*:

    _____ Transplants _____ Research _____ Education

12. I acknowledge that if it is legally required, my body will be subject to autopsy. If autopsy is not required but is desired by my heirs or providers (*Please initial ONE*):

    _____ I DO *or* _____ I DO NOT authorize this procedure.

13. If my provider or the institution in which I am receiving care is either unwilling or unable to honor any of these requests, upon consultation with the Healthcare Representative named in my Durable Power of Attorney for Health dated _____, I want to be transferred to a provider and/or institution that will honor my wishes. I will construe failure to honor this request as denial of my right to receive the treatment I request.

14. I understand that State law requires that 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.

15. I understand that as long as I have the capacity to do so, I can add to, delete from, or otherwise change the wording of this Advance Directive and the related documents at any time, and that any changes will be legally valid if they are consistent with State and Federal law.

16. It is my wish that every part of this Advance Directive be fully implemented. If for any reason any part is held invalid, it is my wish that the remainder of this Advance Directive be implemented.

.

17. I hold blameless and ask my survivors to hold blameless any provider who honors my requests so long as that service meets the community standard of care for treatment of patients in my condition.

18. This Advance Directive supersedes all prior "Living Wills" or similar instruments that I may have signed, and I hereby revoke such prior instruments.

19. I will discuss these options with my MD or ARNP and request a Conditional Medical Order, MOELI, POST, or similar form.

Signature	**Print Name**	**Date**
_____	_____	_____

WITNESS ATTESTATIONS ON FOLLOWING PAGE

STATEMENT OF WITNESS #1

Under penalty of perjury under the laws of the State of _____ (State where document is signed) on this day of _____ 20 ___ at _____ I stipulate that the following is true and correct:

(1) ("Declarer") has been and is personally known to me.

(2) I am **not** (a) related to Declarer by blood, marriage or adoption; (b) entitled to any portion of Declarer's estate upon Declarer's death under any will, or codicil, or any operation of law; (c) declarer's attending physician; (d) an employee of the attending physician or a health facility in which Declarer is a patient; or (e) a person who has a claim against any portion of the estate of Declarer upon Declarer's death.

(3) I believe Declarer to be of sound mind and Declarer signed the foregoing Advance Directive willfully and voluntarily.

_____ _____

Witness Signature Print Name

Address: _____

_____

STATEMENT OF WITNESS #2

Under penalty of perjury under the laws of the State of _____ (State where document is signed) on this day of _____ 20 ___ at _____ I stipulate that the following is true and correct:

(1) ("Declarer") has been and is personally known to me.

(2) I am **not** (a) related to Declarer by blood, marriage or adoption; (b) entitled to any portion of Declarer's estate upon Declarer's death under any will, or codicil, or any operation of law; (c) declarer's attending physician; (d) an employee of the attending physician or a health facility in which Declarer is a patient; or (e) a person who has a claim against any portion of the estate of Declarer upon Declarer's death.

(3) I believe Declarer to be of sound mind and Declarer signed the foregoing Advance Directive willfully and voluntarily.

_____ _____

Witness Signature Print Name

Address: _____

_____

NOTARIZATION (Not required in many states, including Washington)

STATE of _____ County of _____

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

Dated this day of _____ 20 _____ NOTARY PUBLIC in and for the State of _____

Residing at: _____ My commission expires on _____

DURABLE POWER OF ATTORNEY FOR HEALTHCARE

Declaration made this _____ day of _____ (month), 20 _____

I, _____ having the capacity to make healthcare decisions, willfully and voluntarily wish to identify the person and/or people I have chosen to represent me if I temporarily or permanently lose the capacity to make healthcare decisions for myself. If I regain that capacity, I wish to reassert my own right to make decisions pertaining to the treatment that I receive.

1a. I appoint as my **PRIMARY Healthcare Representative**:

Name: _____

Address: _____

Email: _____Phone(s): _____

Relationship to me: _____

1b. If the above named individual is not available to act on my behalf, I appoint the following person as my **ALTERNATE Healthcare Representative**:

Name: _____

Address: _____

Email: _____Phone(s): _____

Relationship to me: _____

1c. If neither of the above named individuals is available to represent me, I authorize my healthcare providers to contact, in order, the following substitute decision-makers as approved for this purpose by the jurisdiction in which I am receiving care, i.e. my spouse or domestic partner, my adult children, my parents; and/or my adult brothers and sisters.

Name	Relationship
1. _____	_____
2. _____	_____

1d. I do not want the following people to participate in planning my end-of-life care.

Name	Relationship
1. _____	_____
2. _____	_____

2. I grant my representative(s) complete authority to make decisions consistent with my stated wishes with regard to starting, refusing, stopping, and/or removing all forms of medical, mechanical, and surgical intervention. I herewith hold my representative(s) blameless for good faith efforts to honor my preferences.

3. If my healthcare representative is unsure about what to decide, I want him or her to please (*initial ONE*):

_____ ignore such doubts and act on my Living Will as written OR

_____ make the best decision he or she can in the face of uncertainty OR

_____ discuss the situation with my doctor, family members, and/or spiritual advisors named below, then use his or her best judgment and after considering their opinions.

Doctor(s) Name: _____

Family Member(s) Name: _____

Spiritual Advisor Name: _____

4. I Do _____ Do Not _____ (initial ONE) want this decision-making authority to extend to decisions that are made after my death with regard to autopsy, organ donation, and the handling of my remains.

5. I instruct my healthcare providers to release to my representative(s) any information about my medical condition, possible treatments, and prognosis pursuant to the attached HIPAA authorization for release of information.

6. This agreement supersedes and replaces any and all formerly executed Durable Power of Attorney Healthcare documents.

Sign only in the presence of witnesses:

Signed this _____ day in the month of _____, 20 _____

Signature: _____ Print name: _____

STATEMENT OF WITNESS #1

Under penalty of perjury under the laws of the State of _____ (State where document is signed) on this day of _____ 20 ___ at _____ I stipulate that the following is true and correct:

(1) ("Declarer") has been and is personally known to me.

(2) I am **not** (a) related to Declarer by blood, marriage or adoption; (b) entitled to any portion of Declarer's estate upon Declarer's death under any will, or codicil, or any operation of law; (c) declarer's attending physician; (d) an employee of the attending physician or a health facility in which Declarer is a patient; or (e) a person who has a claim against any portion of the estate of Declarer upon Declarer's death.

(3). I believe Declarer to be of sound mind and Declarer signed the foregoing Advance Directive willfully and voluntarily.

_____ _____

Witness Signature Print Name

Address: _____

_____

STATEMENT OF WITNESS #2

Under penalty of perjury under the laws of the State of _____ (State where document is signed) on this day of _____ 20 ___ at _____ I stipulate that the following is true and correct:

(1) ("Declarer") has been and is personally known to me.

(2) I am **not** (a) related to Declarer by blood, marriage or adoption; (b) entitled to any portion of Declarer's estate upon Declarer's death under any will, or codicil, or any operation of law; (c) declarer's attending physician; (d) an employee of the attending physician or a health facility in which Declarer is a patient; or (e) a person who has a claim against any portion of the estate of Declarer upon Declarer's death.

(3). I believe Declarer to be of sound mind and Declarer signed the foregoing Advance Directive willfully and voluntarily.

_____ _____

Witness Signature Print Name

Address: _____

_____

NOTARIZATION (Not required in many states, including Washington)

STATE of _____ County of _____

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

Dated this _____ of, _____ 20 ___ NOTARY PUBLIC in and for the State of _____

Residing at: _____ My commission expires on _____

Summary of Important Information to Give to Your Provider

Please place this information in my medical chart.

1. Name: _____ Date of Birth: _____
2. I do have a Living Will dated: _____. Please add my Living Will to my medical record.
3. As a reminder, here are three things I consider to be important for you to know about me.

   a) _____

   b) _____

   c) _____
4. My healthcare representative (surrogate) is:

   Name: _____ Phone: _____ E-mail: _____

   Address: _____
5. I am currently: _____Married _____Living with a Domestic Partner _____ Living with others _____ Living alone

   Name of my spouse or partner: _____ Phone: _____ E-mail: _____

   My partner's address (if not my surrogate): _____

   (*Initial ONE*) _____ I Do _____Do Not grant this person access to my medical records and discussion of my end-of-life care.
6. Listed below are the names and contact information of my alternate healthcare representatives and others I would like to have act on my behalf, in the order listed, if my representative is unavailable.

Name	Relationship	Mailing Address	Phone	E-Mail
Please list anyone that you specifically **DO NOT** want to participate in planning your end-of-life care.				

I will hold you blameless for meeting community standards for the requested care, and have asked my representative and loved ones to do the same. (initial)

Your Signature: _____ Date: _____

On the next page please list all of the medications that you are ***currently taking***.
This information can be a useful reminder for the providers you see regularly,
any new providers you consult, and first responders who answer calls.

Update this information as necessary to make sure it is complete and available in an emergency.

Name: _____ Date: _____

I have the following allergies:

1. _____ 2. _____

3. _____ 4. _____

Check if you: _____use tobacco _____use alcohol _____walk > 20 blocks/day

I have been diagnosed with these critical illnesses:

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Medications and other drugs that **I TAKE NOW**. Include both prescribed drugs and any other over-the-counter drugs, vitamins,

Name of Medication	**Dose Level (mgs, drops etc.)**	**How often do you take it? (Times per day)**	**Who prescribed it? When prescribed?**