

# ADVANCE DIRECTIVE

A step-by-step guide to help  
you make shared health  
care decisions for the future



# Why every adult should have an advance directive

When we turn 18, we can vote, enlist in the military and choose what we would want regarding our health care. Yet all of us could face serious illness or injury at any age.

An advance directive can ease the stress on family members and loved ones if they are faced with critical decisions about your care.

Congratulations on taking the first step toward completing an advance directive. This document allows you to name someone to speak for you if you are unable to speak for yourself. This person will make sure your wishes are honored.

Swedish believes everyone 18 and older should have an advance directive. It provides key information for your doctor and family:

- What kind of medical treatment you want
- Who can make decisions for you if you are unable to make them yourself

## Peace of mind

Advance directives can be simple or detailed. This booklet allows you to decide.

You can simply name someone to make decisions on your behalf. Or you can include instructions about treatments, such as cardiopulmonary resuscitation (CPR), mechanical ventilation (breathing machine) or insertion of a feeding tube.

If you change your mind later about a decision in your advance directive, **you can revise the document at any time.**

If you want to ensure your values, preferences and priorities are respected, then an advance directive can help.

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## Get the most out of your advance directive

### Talk to your loved ones.

Talking to your family members and close friends is very important. They can help in the decision-making process, but remember, you are the expert about what matters most to you. Inform them. Share your thoughts and your choices with them now — before an unforeseen situation arises.

### Talk to your doctor.

Have a conversation with your doctor to make sure he or she understands your preferences and your goals for any future care. It's often easiest to start with the basics. At one of your next visits, talk about what is important to you regarding your health and health care.

Discussing the goals of any medical treatment and care you may receive is always important.

It's especially important if you've had a change in your health or if you're undergoing treatment for a medical condition. Your doctor and other health care providers can make sure your wishes are known and followed, but they can only do this if you have made that information available.

### Record your wishes.

Once you have chosen someone to serve as your health care representative and have decided on your preferences for future care or goals of care, use the forms in this booklet to record your decisions.

### Complete your advance directive.

After you have recorded your health care representative and/or preferences, the document must be witnessed or notarized.

## Return your completed advance directive.

After you and your witnesses (or notary) have signed where indicated, make several copies. Make sure your wishes are recorded in our medical record system. Give a copy to your primary doctor and to your health care representative. If you are ever admitted to a hospital, make sure you or your health care representative gives a copy to your health care team.

Send others **ONLY** a photocopy or scanned version of your advance directive. Keep the original in a safe, easily accessible place.

## Continue the dialogue.

You and your doctor may have several conversations about your health care. Over time your wishes and goals may change. Continuing the dialogue ensures that everyone understands your current preferences.

At any time, you may change your mind about who you want to have serve as your health care representative and about your health care preferences. To update your information, fill out a new advance directive. Tell your health care representative, your family and your doctor that you have revised your forms. Make copies of your updated forms for your health care representative,

your doctor and the hospital medical record file as you did before.

It's never too late or too early to reflect on your goals and wishes.

## Update your advance directive when ...

As circumstances in your life change, it's a good idea to review your health care choices. You may find that you want to adjust your choices depending on new situations. Here are some milestones in life when it is reasonable to review your health care wishes. We call them the Five Ds:

- 1. Decade:** When you start each new decade of your life or when you experience a significant life change, such as when your child turns 18
- 2. Death:** When you experience the death of a loved one
- 3. Divorce:** When you experience a divorce or other major family change
- 4. Diagnosis:** When you are diagnosed with a serious health condition
- 5. Decline:** When you experience a significant decline in your health, especially if you become unable to live on your own





## Frequently asked questions

### What if I don't choose a health care representative?

If you are too sick to make your own decisions, your doctors will turn to family members, friends or a judge to make decisions for you. If you don't have a health care representative, these people may make choices for you that you wouldn't want.

### Will my health care representative be responsible for my medical bills?

No.

### Do I need a lawyer?

No. The law does not require an attorney to complete an advance directive. Two witnesses or a notary public will suffice.

### What happens if I change my mind?

You can change your choices at any time. The best way to make changes is to complete a new advance directive, including signature and witnesses and/or notary public. Inform all those who need to know about your new advance directive.

### What if I do not want to complete the step to make my health care choices (or living will)?

That is fine. When you choose your health care representative (or proxy), talk to them about your wishes.

### What is the difference between an Advance Directive and POLST form?

POLST stands for "Physician Orders for Life Sustaining Treatment." A POLST form complements an advance directive and is not intended to replace it. A POLST form is recommended for any individual with a serious illness, at any age. This form provides medical orders for current treatment that guide actions by ambulance personnel or emergency medical technicians. This form also guides inpatient treatment decisions when it is made available in this setting.

A health care professional completes the form after having a conversation with the patient; the doctor and the patient (or health care representative) must sign the POLST form for it to be valid.

## Completing the form

### The advance directive

Completing an advance directive can be accomplished in five easy steps:

- Step 1:** Choose your health care representative.
- Step 2:** Make your health care choices.
- Step 3:** Outline your health care representative's authority.
- Step 4:** Sign the form.
- Step 5:** Submit a copy of your completed advance directive.



## STEP 1: Choose your health care representative.

Name someone you trust to make health care choices for you if you are unable to make your own decisions. Think about the people in your life — your family and friends. Select someone to be your health care representative. Ask that person if he or she is willing to do this for you.

### Choose a family member or friend who:

- Is 18 or older and 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 this packet to health care providers and family members

### Your health care representative can:

- Decide where you will receive care
- Select or dismiss health care providers
- Say yes/no to medications, tests, treatments
- Say what happens to your body and organs after you die
- Take legal action needed to carry out 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.

## Name your health care representative.

### 1) I want this person to make my medical decisions if I cannot make my own:

First name	Last name	Relationship	
Home/Cell phone	Work phone	Email	
Street address	City	State	ZIP code

### If the first person cannot make my medical decisions, then I want this other person:

First name	Last name	Relationship	
Home/Cell phone	Work phone	Email	
Street address	City	State	ZIP code

### 2) Put an X next to the sentence you agree with:

My health care representative will make decisions for me **only** after I become unable to make my own decisions.

**OR**

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

<b>This advance directive belongs to: (please print your name on this line)</b>	<b>Date of birth</b>
<small>This advance directive and designation of a health care representative 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.</small>	

**STEP 2: Make your health care choices.**

**What makes your life worth living?**

**1) My life is (choose A or B):**

- A) Always worth living no matter how sick I am
- B) Only worth living if (check 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

**2) If I am dying, it is important for me to be (choose one):**

- At home
- In a hospital or other care center
- It is not important to me where I am cared for

**Religion or spiritual beliefs**

**1) Is religion or spirituality important to you?**

- Yes     No

**2) Do you have a religion or faith tradition? If so, what is it?**

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**3) What should your doctors know about your religious or spiritual beliefs?**

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## STEP 2: Make your health care choices, continued.

### Life support

Life-support procedures may be used to try to keep you alive. They include:

**CPR or cardiopulmonary resuscitation** — This may involve:

- Pressing hard on your chest to keep your blood pumping
- Electrical shocks to jump-start your heart
- 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 able to talk or eat when you are on the machine.



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

**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.

**Blood transfusion** — This will put blood in your veins.

### Surgery and/or medicines



**Put an X next to the one statement you most agree with.**

**If I am so sick that I may die soon:**

- 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 am 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 my comfort. I prefer to have a natural death.
- I want my **health care representative** to decide.
- I am not sure what I would like done.

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## STEP 2: Make your health care choices, continued.

### Donating your organs

Your doctors may ask about organ donation and an autopsy after you die. Donating your organs can help save lives. Put an **X** next to the **one** choice you most agree with.

- I **want** to donate my organs:
  - Any organ, all that might be usable.
  - Only certain organs (please specify which organs or tissues you wish to donate).

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- I **do not** want to donate any of my organs.
- I want my **health care representative** to decide.
- I am not sure what I would like done.

### Autopsy

An autopsy can be done after death to find out why someone died. It's a surgical procedure. It can take a few days. In some cases an autopsy may be required by law. Put an **X** next to the **one** choice you most agree with.

- I **want** an autopsy.
- I **do not** want an autopsy.
- I want an autopsy **only if there are questions** about the cause(s) of my death.
- I want my **health care representative** to decide.
- I am not sure what I would like done.

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## STEP 3: Outline your health care representative's authority.

Your health care representative can help make the following decisions about:

### Life-support treatments—medical care to help you live longer:

- CPR or cardiopulmonary resuscitation
- Breathing machine or ventilator
- Dialysis
- Feeding tube
- Blood transfusion
- Surgery
- Medicines

### End-of-life care

If you might die soon, your health care representative can:

- Call a spiritual leader
- Decide if you die at home or in the hospital
- Decide whether an autopsy will be performed
- Decide whether your organs may be donated
- Decide where you should be buried or cremated

### How do you want your health care representative to follow your medical wishes?

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

- Total flexibility:** It is OK for my health care representative to change **any** of my medical decisions 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 to change **some** of my medical decisions 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 medical wishes as closely as possible. Please respect my decisions even if doctors recommend otherwise.

### Use additional pages, if necessary, to answer the questions below.

These are some of my wishes I really want respected:

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Write down any decisions you **do not** want your health care representative to make:

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## STEP 4: Sign the form.

### Your signature

#### Before this form can be used, you must:

- Sign this form if you are at least 18
- Have two witnesses sign the form **or** have it notarized by a notary public
- Sign the form in front of your witnesses or have a notary public acknowledge that you signed the form

#### Sign your name and write the date.

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Signature

Date

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Print name

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Street address

City

State

ZIP code

### Witnesses

Before this form can be used, you must have two witnesses sign the form **or** a notary public notarize it.

#### Your witnesses must:

- Be at least 18
- Know you
- See you sign this form

#### Your witnesses cannot:

- Be the person you named as your health care representative
- Be your doctor or other health care provider
- Work for your medical center or health care provider
- Work at the place where you live
- Be related to you in any way
- Benefit financially — be eligible for any money or property — after you die

**If you do not have two witnesses, a notary public can sign on page 13.**

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## STEP 4: Sign the form, continued.

### Witnesses' signatures

Have your witnesses complete this page.

By signing, I promise that I saw \_\_\_\_\_ sign this form.

I believe he/she was thinking clearly and was not forced to sign this form.

#### I also promise that:

- I know this person and he/she could prove who he/she was
- I am at least 18
- I am not his/her health care representative
- I am not his/her health care provider
- I do not work for his/her health care provider
- I do not work where he/she lives
- I am in no way related to him/her
- I will not benefit financially — be eligible for any money or property — after he/she dies

#### Witness #1

_____ Signature		_____ Date	
_____ Print name			
_____ Street address	_____ City	_____ State	_____ ZIP code

#### Witness #2

_____ Signature		_____ Date	
_____ Print name			
_____ Street address	_____ City	_____ State	_____ ZIP code

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— OFFICIAL USE ONLY —

**STEP 4: Sign the form — Notary public signature, if needed.**

The notary public will require that you have photo ID, such as a driver’s license or passport, with you.

**State of Washington**

County of \_\_\_\_\_

I certify that I know or have satisfactory evidence that

\_\_\_\_\_

(Name)

is the person who appeared before me, and said person acknowledged that he/she signed this instrument and acknowledged it to be his/her free and voluntary act for the uses and purposes mentioned in the instrument.

Dated: \_\_\_\_\_

\_\_\_\_\_

(Signature of Notary Public)

Title: \_\_\_\_\_

*(Notary Seal)*

My appointment expires: \_\_\_\_\_

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## STEP 5: Submit a copy of your completed advance directive.

Once you have signed your advance directive and it has been witnessed **or** notarized, keep the original and make copies of pages 5-14 to give to your:

- Health care representative
- Medical providers
- Hospital
- Family and friends

### Options for returning your completed advance directive:

Return a COPY to your preferred Swedish Health Services doctor, primary care clinic or hospital at your next visit.

You may also return a COPY by using the self-addressed stamped envelope (if you were provided one).

### More information about completing or returning your advance directive is available on the following Swedish and Providence web sites:

- [www.swedish.org/AD](http://www.swedish.org/AD)
- [www.swedish.org/patient-visitor-info](http://www.swedish.org/patient-visitor-info) (click on the "Advance Directive" link)
- [www.providence.org/InstituteForHumanCaring](http://www.providence.org/InstituteForHumanCaring)

**If you have further questions, please contact your preferred Swedish Health Services doctor, primary care clinic or hospital.**

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# 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. We do not exclude people or treat them differently because of race, color, national origin, age, disability or sex. We:

- (1) Provide 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) Provide 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 us by contacting the civil rights coordinator for your service location as listed below:

<b>Service location</b>	<b>Civil rights coordinator</b>
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: Nondiscrimination.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>.

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 աջակցություն անվճար ծառայություններ: Ջանդախեք 888-311-9127 (Swedish Edmonds 888-311-9178) (հեռադիպ (TTY) 711).

يرجى 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 ਧਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਿ ਚੋ, ਤਾਂ ਤਾਮਾ ਯਵਿੰਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 888-311-9127 (Swedish Edmonds 888-311-9178) (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

សូមចាំអារម្មណ៍: ប្រសិនបើលោកអ្នកនិយាយភាសាខ្មែរ 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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