YOUR GUIDE TO

Advance Care Planning

OVERLAKE | MEDICAL CENTER & CLINICS

Why every adult should have an Advance Directive

What if a sudden illness or injury left you unable to speak for yourself?
How would your healthcare providers know what treatment you would want?

Thinking and talking about this before you need it is called Advance Care Planning. This information can be written down in an Advance Directive, also sometimes referred to as a Healthcare Directive. It also allows you to appoint someone as a healthcare agent to act on your behalf if you lose the ability to make decisions. This is called a Durable Power of Attorney for Healthcare.

Overlake Medical Center & Clinics believe that Advance Care Planning is an important part of routine healthcare for all adults, age 18 and above. We hope that you will always be healthy, active and in control of your own decisions. However, we know that life can be unpredictable, and we want to give you the best care possible. Knowing your wishes will help us to do so.

OTHER RESOURCES

- agingwithdignity.org (Five Wishes)
- caringinfo.org
- endoflifewashington.org
- honoringchoicespnw.org
- overlakehospital.org/acp
- prepareforyourcare.org
- theconversationproject.org
- wsma.org

THE ADVANCE CARE PLANNING PROCESS

It starts with thinking:

- What matters most to you?
- What are your past experiences with healthcare?
- What are your spiritual and religious beliefs?
- How do those things influence your choices about future health care decisions?

STEP 1: MAKING YOUR HEALTHCARE CHOICES

What gives your life value, meaning and purpose? (check all that apply)

- ☐ My life is worth living no matter how sick I am.
- ☐ Communicating with family and friends.
- ☐ Knowing who I am and who I am with.
- ☐ Being free from pain.
- ☐ Being physically and mentally able to do the things I love.
- ☐ Being able to feed, bathe and take care of myself.
- ☐ Living without being hooked up to or dependent on machines.
- ☐ Other: _____

Which of the following are important to you? (check all that apply)

- ☐ Letting nature take its course.
- ☐ Maintaining my quality of life.
- ☐ Living as long as possible, regardless of quality of life.
- ☐ Leaving good memories for family and friends.
- ☐ Making a contribution to medical research or teaching.
- ☐ Being able to leave money to family, friends, charity.
- ☐ Not prolonging my dying.
- ☐ Other: _____

Which of these things would be very hard on your quality of life? (check all that apply)

- ☐ Being in a coma and not able to wake up or talk to my family and friends.
- ☐ Not being able to live without being hooked up to machines.
- ☐ Not being able to think for myself.
- ☐ Not being able to feed, bathe or take care of myself.
- ☐ Not being able to live on my own.
- ☐ Having constant, severe pain or discomfort.
- ☐ Other: _____

RELIGIOUS/SPIRITUAL BELIEFS

Is religion or spirituality important to you?

☐ Yes ☐ No

Do you have a religion, faith or cultural tradition?

_____

_____

What should your medical provider or healthcare agent know about your religious, spiritual or cultural beliefs?

_____

_____

If you are dying, where do you want to be?

- ☐ At home. ☐ In a hospital or facility.
- ☐ Doesn't matter.

Name: _____ Date of Birth: _____

LIFE SUPPORT

Life support treatments are used to try to keep you alive. These include:

- **CPR**: 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**: A machine that pumps air into your lungs and breathes for you when you cannot breathe on your own. While you are on a ventilator, you are unable to talk or eat.
- **Dialysis**: A machine with a filter is used to clean your blood if your kidneys stop working.
- **Feeding tube**: A tube used to feed you if you cannot swallow. The tube may be passed down your throat to your stomach or surgically inserted through your abdomen to your stomach to put nutritional liquids directly into the digestive system.

Answer the following questions, keeping in mind your thoughtful reflection on past experiences, what makes life worth living for you, and your cultural, spiritual and religious beliefs.

Do you have strong feelings about any of these life support treatments?

_____

_____

_____

_____

_____

If I am unable to communicate my healthcare decisions, I do not want my life to be prolonged by life support treatments in the following situations (initial any or all that apply):

_____ I have a condition that cannot be cured and that will result in my death within a relatively short period of time.

_____ I become unconscious and my doctors determine that, to a high degree of medical certainty, I will never regain consciousness.

_____ I suffer from advanced dementia or any other condition which results in the substantial loss of my ability to think, and my doctors determine that, to a high degree of medical certainty, this is not going to get better.

Name: _____ Date of Birth: _____

ORGAN DONATION

☐ I want to donate my organs or body parts.
Which organ or body part do you want to donate?

_____

☐ I do not want to donate my organs or body parts.

☐ I want my healthcare agent to decide.

AUTOPSY

An autopsy can be done after death to find out why someone died. It is done by surgery and can take a few days.

☐ I want an autopsy.

☐ I do not want an autopsy.

☐ I only want an autopsy if there are questions about my death.

☐ I want my healthcare agent to decide.

What else would you like your healthcare providers and healthcare agent to know about your wishes?

_____

_____

_____

_____

_____

_____

_____

_____

_____

Name: _____ Date of Birth: _____

STEP 2: CHOOSE YOUR HEALTHCARE AGENT

Think about whom you can trust to make your healthcare decisions, even during emotional and stressful times. Select a primary healthcare agent (and one or two alternates) 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 healthcare providers and family members.
- Will have an ongoing conversation with you about your health and your wishes.

Your decision maker 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.

When you are not able, your healthcare agent can:

- Decide where you will receive care.
- Select or dismiss healthcare 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.

NAME YOUR HEALTHCARE AGENT AND OUTLINE HIS/HER AUTHORITY.

I want this person to make my medical decisions if I am not able to make my own:

First Name: _____ Last Name: _____

Phone Number #1: (_____) _____ - _____ Phone Number #2: (_____) _____ - _____

Relationship: _____

Address: _____

Street Address City State Zip Code

If this person cannot do it, then I want this person to make my medical decisions:

First Name: _____ Last Name: _____

Phone Number #1: (_____) _____ - _____ Phone Number #2: (_____) _____ - _____

Relationship: _____

Address: _____

Street Address City State Zip Code

Name: _____ Date of Birth: _____

How do you want your healthcare agent to follow your medical decisions?

☐ **Total flexibility**: It is okay for my decision maker to change any of my medical decisions if my doctors think it is best for me at that time

☐ **Some flexibility**: It is okay for my decision maker to change some of my decisions if the doctors think it is best. But these wishes I NEVER want changed:

_____

☐ **No flexibility**: I want my decision maker to follow my medical wishes exactly. It is NOT okay to change my decisions, even if the doctors recommend it.

Other things to consider or that your providers and healthcare agent should know about you and your choices for medical care:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Name: _____ Date of Birth: _____

STEP 3: SIGN THE FORM

I understand that two witnesses OR a notary must watch me sign this form and complete their section.

Sign your name and write the date.

Signature: _____ Date: _____

Print Name: _____

Address: _____

Street Address City State Zip Code

OPTION 1 – TWO WITNESSES SIGNATURES

The declarer has been personally known to me and I believe him or her to be of sound mind. In addition:

- I am not their healthcare provider.
- I do not work for their healthcare provider.
- I am not their home care provider.
- I do not work where they live.
- I am not related to them by blood, marriage or domestic partnership.
- I will not benefit financially after they die.

Witness #1

Signature: _____ Date: _____

Print Name: _____

Address: _____

Witness #2

Signature: _____ Date: _____

Print Name: _____

Address: _____

Name: _____ Date of Birth: _____

OPTION 2 – NOTARY

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 _____

Advance Directive

STEP 4: SHARE YOUR ADVANCE DIRECTIVE

Keep the original version and provide copies of your signed and witnessed or notarized Advance Directive to your:

- Healthcare agent(s).
- Medical providers.
- Most utilized hospital.
- Family and friends.

A good guideline is to review your Advance Directive when there are major changes in your life, such as when you:

- Start each new decade of your life, or when you experience a significant life change.
- Experience the death of a loved one.
- Experience a divorce or other major family change.
- Are diagnosed with a serious health condition.
- Experience a significant decline in your health, especially if you become unable to live on your own.

Frequently asked questions

Will my healthcare agent be financially 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 and/or notary public will suffice.

What happens if I don't choose a healthcare agent?
If you cannot make medical decisions for yourself and do not choose a healthcare agent, your doctors will follow your state's law to find a decision maker for you. In Washington, these individuals in order of priority are:

1. A guardian with healthcare decision-making authority, if one has been appointed.
2. The person named in the durable power of attorney with healthcare decision-making authority.
3. Your spouse or state-registered domestic partner.
4. Your adult children.
5. Your parents.
6. Your adult brothers and sisters.
7. Your adult grandchildren who are familiar with you.
8. Your adult nieces and nephews who are familiar with you.
9. Your adult aunts and uncles who are familiar with you.
10. Your close friend who can show facts and circumstances demonstrating closeness and knowledge of your values and wishes. Overlake has an approved declaration form that this friend can complete and sign to be considered as your surrogate decision maker.

When there is more than one person in a class, such as multiple children or siblings, all individuals in that class must agree on the healthcare decision. This is one of the reasons why it is important for you to make your wishes known to your family members and for you to choose your own healthcare decision maker.

What if I change my mind?
You can always revoke one or both of your Washington state directives (Advance Directive and/or Durable Power of Attorney for Healthcare). If you choose to revoke your documents, make sure you notify your healthcare agent, alternate agents, your family and your doctor(s). If you wish to make changes to the directives, you should complete new documents.

OVERLAKE MEDICAL CENTER & CLINICS

1035 116th Ave NE
Bellevue, WA 98004

overlakehospital.org

Below is a wallet card that you can complete, cut out and store in your wallet, purse or anything that you carry with you regularly.

ATTENTION HEALTHCARE PROVIDERS

My Name: _____

My Date of Birth: _____

MY DOCTOR

Doctor Name: _____

Doctor Phone: (_____) _____ - _____

PLEASE HONOR MY WISHES

My Healthcare Agent (Identified on DPOAH):

_____

Phone: (_____) _____ - _____

My Advanced Directive is on file at:

_____

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