Advance Directive - WASHINGTON

Providence St. Joseph Health

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.

This advance directive belongs to: (please print your name on this line) **Date of Birth**

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?

_____

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

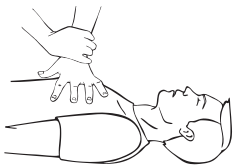
_____

_____

_____

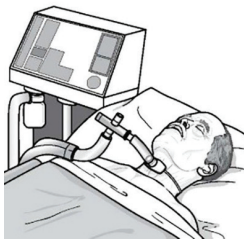
Step 2: Make your health care choices, continued.

Life support



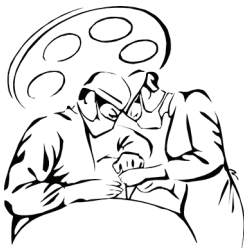
Life-support procedures may be used to try to keep you alive. They include:

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.

This advance directive belongs to: (please print your name on this line) **Date of Birth**

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).

_____

_____

___ 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.

Step 2: Make your health care choices, continued.

Other things to consider

What other wishes are important to you after you die? For example, are there any cultural, religious, or spiritual things about how to treat your body that your health care team should know?

Do you have someone who should be contacted for funeral or burial wishes? If yes, who?

This advance directive belongs to: (please print your name on this line) **Date of Birth**

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:

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

This advance directive belongs to: (please print your name on this line) **Date of Birth**

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.

By signing, I revoke any prior advance directive.

Signature _____ Date _____

Print name _____

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 or related to the person 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 your die

If you do not have two witnesses, a notary public can sign on page 9.

Step 4: Sign the form, continued.

Witnesses' signatures

Have your witnesses complete this page.

By signing, I promise that I saw _____ sign this form.
Name of advance directive owner

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 related to 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 _____

This advance directive belongs to: (please print your name on this line) **Date of Birth**

— OFFICIAL USE ONLY —

Step 4: Sign the form - Notary public signature, if needed.

Take this form to a notary public **ONLY** if two witnesses have not signed. 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: _____

My appointment expires: _____ (Notary Seal)

Step 5: Submit a copy of your completed advance directive.

Once you have signed your advance directive and it has been witnessed and/or notarized, keep the original and make copies of pages 1-9 to send to your:

- Health care representative
- Family
- Friends
- Medical providers
- Hospital

Options for returning your completed advance directive:

1. Return a **COPY** to your preferred Providence St. Joseph Health doctor or hospital at your next visit.
2. Return a **COPY** by using the self-addressed stamped envelope (if available).
3. Return by fax to your Providence St. Joseph Health hospital:

Providence Holy Family Hospital
Providence Centralia Hospital
Providence Mount Carmel Hospital
Providence St. Mary Medical Center
Providence St. Peter Hospital
Fax to 509-482-2187

Providence Regional Medical Center Everett
Fax to 425-317-0701

Providence Sacred Heart Medical Center
Fax to 509-474-4815

Providence St. Joseph's Hospital (Chewelah)
Fax to 509-935-5233

For hospitals not listed, please contact your hospital for the correct fax number.

If you have any questions related to completing or returning your advance directive, please contact us at:

Providence.org/InstituteForHumanCaring
424-212-5444

Revised 07/2019

With special thanks to:

- Rebecca Sudore, M.D., Division of Geriatrics, University of California, San Francisco
- Cedars-Sinai, Los Angeles, CA

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 we have 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 state as listed below:

Region/Ministry	Civil Rights Coordinator
Alaska	Civil Rights Coordinator, 3200 Providence Dr., Anchorage, AK 99508; Tel:1-844-469-1775; Email: Nondiscrimination.AK@providence.org
Southern California	Civil Rights Coordinator, 501 S. Buena Vista St., Burbank, CA 91505; Tel:1-844-469-1775; Email: Nondiscrimination.CA@providence.org
Hoag Memorial	Civil Rights Coordinator, One Hoag Drive, Newport Beach, CA 92663; Tel: 949-764-4427; Email: kimberlee.rosa@hoag.org
Northern California	Civil Rights Coordinator, 1165 Montgomery Drive, Santa Rosa, CA 95405; Tel: 707-525-5621; Email: Nondiscrimination-NCAL@stjoe.org
Montana	Civil Rights Coordinator, 1801 Lind Ave. SW, Renton, WA 98057; Tel: 1-844-469-1775; Email: Nondiscrimination.MT@providence.org
Texas/New Mexico	Civil Rights Coordinator, 3506 21st Street, Suite 301, Lubbock, TX 79410; Tel: 806-725-0085; Email: Nondiscrimination.TX.NM@covhs.org
Oregon	Civil Rights Coordinator, 5933 Win Sivers Dr., Suite 109, Portland, OR 97220; Tel:1-844-469-1775; Email: Nondiscrimination.OR@providence.org
Washington	Civil Rights Coordinator, 101 W. 8th Avenue, Spokane, WA 99204; Tel:1-844-469-1775; Email: Nondiscrimination.WA@providence.org
PSJH Home and Community Care	Civil Rights Coordinator 2811 S. 102nd St,Suite 220, Tukwila, WA 98168; Tel:1-844-469-1775; Email: Nondiscrimination.pscs@providence.org

For Legacy St. Joseph Health ministries: Interpreter services are provided by:

- Staff with multi-lingual fluency that have been certified by the facility
- Pacific Interpreter Service
- California Relay Service (800) 755-2922
- Other assistive resources as available
- Medical Emergency Network for the Deaf (MEND) (800) 422-7444

For Legacy Providence Health & Services ministries: Individuals needing Telecommunications Relay Services to file a complaint, may call 1-800-833-6384, or 7-1-1.

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 Avenue 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.

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

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

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

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Եթե խոսում եք հայերեն, ապա ձեզ կարող են տրամադրվել լեզվական աջակցության անվճար ծառայություններ: Զանգահարեք 888-311-9127 (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 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 (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 (TTY:711) まで、お電話にてご連絡ください.

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

សូមចាំអារម្មណ៍៖ ប្រសិនបើលោកអ្នកនិយាយភាសាខ្មែរ នោះសេវាជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនលោកអ្នក ដោយឥតគិតថ្លៃ។ សូមទូរស័ព្ទទៅលេខ 888-311-9127 (TTY: 711)។

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 888-311-9127 (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 (TTY: 711).

โปรดทราบ: หากคุณพูดภาษาไทย คุณสามารถใช้บริการความช่วยเหลือทางภาษาได้โดยไม่มีค่าใช้จ่าย โทร 888-311-9127 (TTY: 711)

The wallet card

Please fill in the blanks, punch out the card and carry it in your wallet.

In case of emergency, it will alert your health care team that you have named someone to be your health care representative and that you have completed an advance directive. This will help ensure your wishes are followed if you are in a situation where you cannot speak for yourself.

IN CASE OF EMERGENCY

I have a health care representative who can speak for me if I am unable to communicate.

FULL NAME _____

PHONE _____

ALT. PHONE _____

RELATIONSHIP TO ME _____

For more information, please visit
www.instituteforhumancaring.org

Download advance directives at
Provhealth.org/AD

PROVIDENCE Health & Services

FACEY MEDICAL GROUP

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