HEALTH-CARE DIRECTIVE

Directive made this _____day of _____, _____ (month, year) I, _____(name), having the capacity to make health-care decisions, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, and do hereby declare that:

(a) If at any time I should be diagnosed in writing to be in a terminal condition by the attending physician, or in a permanent unconscious condition by two physicians, and where the application for life-sustaining treatment would serve only to artificially prolong the process of my dying, I direct that such treatment be withheld or withdrawn, and that I be permitted to die naturally. I understand by using this form that terminal condition means incurable and irreversible condition caused by injury, disease, or illness that would within reasonable medical judgment cause death within a reasonable period of time in accordance with accepted medical standards, and where the application of life-sustaining treatment would serve only to prolong the process of dying. I further understand in using this form that a permanent unconscious condition means an incurable and irreversible condition in which I am medically assessed within reasonable medical judgment as having unreasonable probability of recovery from an irreversible coma or persistent vegetative state.

(b) In the absence of my ability to give directions regarding the use of a life-sustaining treatment, it is my intention that this directive shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and I accept the consequences of such refusal. If another person is appointed to make these decisions for me, whether through a durable power of attorney or otherwise, I request that the person be guided by this directive and any other clear expressions of my desires.

(c) If I am diagnosed to be in terminal condition or in a permanent unconscious condition (check one):

☐ I DO want to have artificially provided nutrition and hydration.

☐ I DO NOT want to have artificially provided nutrition and hydration.

PT. NO.

NAME

DOB

UW Medicine
Harborview Medical Center - UW Medical Center
University of Washington Physicians
Seattle, Washington

HEALTH CARE DIRECTIVE

U0285

UH0285 REV JAN 05

ADVANCE DIRECTIVE – **GOLD**

(d) 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.

(e) I understand the full import of this directive and I am emotionally and mentally capable to make the health-care decisions contained in this directive.

(f) I understand that before I sign this directive, I can add to or delete from or otherwise change the wording of this directive and that I may add or delete from this directive at any time and that changes shall be consistent with Washington State law or federal constitutional law to be legally valid.

(g) It is my wish that every part of this directive be fully implemented. If for any reason any part is held invalid, it is my wish that the remainder of my directive be implemented.

_____ _____

Signed Date

_____

City, County, and State Residence

_____

Date of Birth

The declarer has been personally known to me and I believe him or her to be capable of making health-care decisions.

_____ _____

Witness Date

_____ _____

Witness Date

[NOTE: Washington State law specifically prohibits an attending physician, his or her employees, or employees of a health-care facility in which the declarer is a patient or any person who has a claim against any portion of the estate of the declarer upon declarer's decease at the time of the execution of the Directive from witnessing a Health-Care Directive; thus medical center staff, employees, and volunteers shall not witness this document.]