

SELDEN & YOUNGS PLLC

HEALTH CARE DECISION MAKING QUESTIONNAIRE

In the event you are unable to make your own health care decisions, two documents will become very important. The first is the Durable Power of Attorney for Health Care, and the second is the Directive to Physicians, also known as the Living Will. The following questionnaire will help you think through these issues, and will provide the basis for drafting comprehensive directives. Please note that by signing this, you have NOT created a legal document. The documents must be properly drafted and properly executed in order for them to be valid.

Your Full Legal Name

Your date of birth

Your Address, Street, City, State, County

Health Care Decision Making

In the event your are unable to make your own health care decisions, please state the full legal name and address of the primary person you would want to make such decisions:

Full Legal Name

Relationship to You

City, State and County in which they reside

In the event that person was unable to fulfill this responsibility, please name an alternate person:

Full Legal Name

Relationship to You

City, State and County in which they reside

Are there specific treatments that you want to specifically exclude from your care?

_____ Yes _____ No _____ Give my designee discretion to make those decisions

If yes, please describe treatments you would not want to receive:

Do you have a history of mental illness or want to discuss a mental health advance directive? If so, Washington law allows you to complete special powers of attorney with regard to mental illness.

Are you the member of a religion that has specific prohibitions on care, such as the Christian Scientists or Jehovah's Witness? If so, do you want to incorporate these values into your power of attorney?

Please list other concerns you have in your care that you would want to incorporate into the power of attorney: (Check all that apply)

A. _____ 1. If I have no reasonable expectation of recovery or chance of regaining a meaningful quality of life in these medical conditions as determined by my attending physician and at least one additional physician, I direct that life-sustaining procedures be withheld or withdrawn in circumstances of: (check all that apply)

- _____ terminal illness
- _____ permanent unconsciousness
- _____ persistent vegetative state
- _____ unrecoverable semi-conscious state
- _____ incurable and irreversible chronic diseases
- _____ extreme mental deterioration
- _____ whole brain death

OR

___ 2. I direct that all medically appropriate measures be provided to sustain my life, regardless of my physical condition.

- B.** This section asks you to think about the values that are important to you regarding treatment in case of severe mental or physical illness.

___ 1. I do not wish my life to be prolonged by medical treatment(s) if my quality of life is unacceptable to me. The following are conditions that are **un**acceptable to me. (Check only those that describe a way of living that you could not tolerate):

- ___ a) Permanently unconscious with a ventilator breathing for me.
- ___ b) Permanently unconscious with a feeding tube and/or intravenous (IV) hydration.
- ___ c) On a ventilator when there is little or no change of recovery.
- ___ d) Being conscious (awake), but unable to communicate (for example, with a stroke), and being fed with a feeding tube and/or hydrated with IVs to keep me alive.
- ___ e) Living with a dementia like Alzheimer's disease so severe that I am unable to recognize those who love me.

OR

___ 2. I want to live as long as possible, regardless of the quality of life that I experience.

- C.** In the circumstances described in A.1., above, I also direct that the following life-sustaining procedures be withheld or withdrawn

- ___ surgery
- ___ antibiotics
- ___ cardiac resuscitation
- ___ respiratory support
- ___ chemotherapy
- ___ radiation
- ___ dialysis
- ___ transfusion.

- D.** Initial the following if it applies to you:

___ I also direct that artificially provided nutrition and fluids be withheld and withdrawn and that I be allowed to die.

- E.** Upon my death, I am willing to donate

- ___ a) any parts of my body that may be beneficial to others, or
- ___ b) my entire body (except corneas which may be donated separately) to a medical school for use in teaching and/or research.

F. Special instructions re: funeral/cremation:

G. Any other instructions not covered in this questionnaire

Signature: _____

Date: _____