

ALBERTSON LAW GROUP, P.S.

Healthcare Directive Questionnaire

Instructions:

- Please fill out this questionnaire as completely as possible and return it to our office before your initial appt. or bring it with you when you meet with the attorney (if you are unable to complete the questionnaire, the attorney will assist you during your initial consultation).
- The information that you provide is **confidential** and will not be shared without your permission.
- Please fill in the full legal names of all people listed in the questionnaire (even if the person will not be specifically mentioned). Please do not use nicknames unless specifically requested.
- Please remember, you can always change the options you write in this questionnaire during the drafting process or by amending your documents after you have signed them.
- This is a generic questionnaire so if questions do not apply to you, write N/A.
- Please think about who you would like to name as your personal representative, your successor trustees and guardians for your children if appropriate.

Your documents will be based on the information you provide. To that end, please read and sign the following statement:

I understand that my Estate Plan will be based on the information provided herein. I further understand that my responses to the questionnaire are confidential and will not be shared without my permission. I affirm that the information provided herein is full, complete and accurate to the best of my present knowledge.

Dated: _____ Signed: _____

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How Can We Best Serve You?

Have you met with an Albertson Law Group, P.S. attorney before? Yes No

If yes, who did you meet with and when? _____

How did you hear about our firm? Professional Referral Newspaper Mailing Internet
Radio

Friend or Family Referral Other _____

If referred, who referred you? . _____

Your Email addresses _____

If possible, please use *full legal names* (first, full middle and last) when asked for names.

PART I: HEALTH CARE DECISION MAKING

In the event you 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: _____

County in which they reside: County: King Snohomish Pierce Other _____

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

Full Legal Name: _____

Relationship to you: _____

City, State: _____

County in which they reside: County: King Snohomish Pierce Other _____

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? 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. I direct that life-sustaining procedures be withheld or withdrawn in circumstances of:
(check all that apply, do not check those that you would not want to be withheld or withdrawn)

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

The above conditions shall have no reasonable expectation of recovery or chance of regaining a meaningful quality of life. My attending physician and at least one additional physician shall determine these medical conditions. I understand that I will be kept comfortable.

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 unacceptable 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.

Check 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.

D. ___ 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.

