

ALBERTSON LAW GROUP, P.S.

Attorneys and Counselors at Law

HEALTH CARE DECISION MAKING QUESTIONNAIRE

Filling out the Questionnaire

- Your Information will be held in *strictest confidence*.
- You should fill in the full legal names of all people listed in the questionnaire (even if the person will not be specifically mentioned). Please avoid the use of nicknames unless specifically asked for.
- Please remember, you can always change the decisions you make here 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, simply write in N/A.

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 this is NOT a legal document. The documents must be properly drafted and properly executed in order for them to be valid.

Full Legal Name: _____

Date of Birth: _____

Address, City, State: _____

Kent Office
124 4th Avenue South
Suite 200
Kent, WA 98032
☎ (253) 852-8772
☎ (253) 852-8770

Bellevue Office
11100 Northeast 8th Street
Suite 380
Bellevue, WA 98004
☎ (425) 462-6132
☎ (425) 576-4040

Toll-Free: (877) 246-8772

✉ lawyers@albertsonlaw.com

💻 www.albertsonlaw.com

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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 **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.

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.

