end of life
WASHINGTON
Your life. Your death. Your choice.

Durable Power of Attorney for Health Care and Health Care Directive of:

BRUCE SALAMANDIR-FEYRECILDE
(Your name here.)

This document states my choices about use of life-sustaining medical treatment and comfort care. It is meant to inform and guide whoever will make health care decisions for me, if I become unable to make my own health care decisions. I understand that such inability may only be temporary. When I can make my own health care decisions I want to do so.

Even when I cannot make my own health care decisions, I want my physician and my health care decision maker(s) to talk to me honestly about my condition and treatment.

I want this directive to remain in effect after my death for autopsy, organ donation, use of my body for medical research, and for my agent to arrange for the disposition of my remains, if I authorize that in section 9.

(Continued on next page)

1. MY HEALTH CARE AGENT

I appoint as my primary agent:

Name MONIQUE FEYRECILDE

Address 26481 SE 225TH ST. MAPLE VALLEY, WA 98038

Telephone 425-221-1882
(day) (evening) (mobile)

My alternate agent (optional):

If my primary agent is unable or unwilling to serve, or is unavailable when decisions need to be made for me, then I name this alternate agent:

Name _____

Address _____

Telephone _____
(day) (evening) (mobile)

If my alternate agent acts for me because my primary agent is unavailable, I intend that the alternate agent act only until my primary agent is available.

2. THE AUTHORITY I GIVE MY AGENT

I grant my agent complete authority to make all decisions about my health care. This includes, but is not limited to (a) consenting, refusing consent, and withdrawing consent for medical treatment recommended by my physicians, including life-sustaining treatments; (b) requesting particular medical treatments; (c) employing and dismissing health care providers; (d) changing my health care insurers; (e) signing a Physician Orders for Life-Sustaining Treatment (POLST) form; (f) transferring me to another facility, private home, or other place; and (g) accessing my medical records and information.

This authority applies to information governed by the Health Insurance Portability and Accounting Act (HIPAA) of 1996 and any further changes to HIPAA.

3. WHY I AM MAKING THIS DOCUMENT/ HOW TO MAKE HEALTH CARE DECISIONS FOR ME

I want whoever makes health care decisions for me to do as I would want in the circumstances, based on the choices I express in this document. I do not want others to substitute their choices for mine because they disagree with my choices or because they think their choices are in my best interest. I do not want my intentions to be rejected because someone thinks that if I had more information when I completed this document, or if I had known certain medical facts that developed later, I would change my mind. If what I would want is not known, then I want decisions to be made in my best interest, based on (a) my values, (b) the contents of this document, and (c) medical information provided by my health care providers.

BGK I have completed and attached an additional statement of my values. (Optional)

4. WHEN I DO NOT WANT LIFE-SUSTAINING TREATMENT

I value life very much, but I believe that to be kept alive in certain circumstances is worse than death. If I initial an item in this section it means that if such an initialed life-threatening event should occur, I would not want to receive life-sustaining treatment. I want my care-givers to focus on comfort care and pain management, and I should be allowed to die as peacefully as possible (initial all that apply):

BGK a. Unconsciousness or coma that probably will prevent me from communicating, permanently.

BGK b. Irreversible dementia such as Alzheimer's Disease.

BGK c. Total dependence on others for my care because of physical deterioration, which is probably permanent.

BGK d. Pain which probably cannot be eliminated, or can be eliminated only by sedating me so heavily that I cannot converse.

_____ e. Below are other circumstances in which I would not want life-sustaining treatment: (Optional)

5. WHEN I MAY WANT TEMPORARY USE OF LIFE-SUSTAINING TREATMENT

I understand that I could become unconscious or unable to communicate, *temporarily*. If I were to become unconscious or unable to communicate temporarily, then (initial only **ONE** line):

BBT I would want to receive life-sustaining treatment, for up to 4 weeks (please specify).

_____ I would want to receive life-sustaining treatment for a period of time determined by my health care agent, based on the judgement of my doctor(s).

_____ I still would want no life-sustaining treatment.

6. LIFE-SUSTAINING TREATMENTS I DO NOT WANT

If I experience a condition in which I would not want life-sustaining treatment (as documented in Section 4), or if I experience a quality of life my agent believes I would consider unacceptable, I **do not want** the following life-sustaining treatments started. If already started, I want them stopped.

(Initial all that you **do not want.**)

BBT **All** cardiopulmonary resuscitation (CPR) measures to try to restart my heart and breathing, if those stop, including artificial ventilation, stimulants, diuretics, heart regulating drugs, or any other treatment for heart failure.

BBT Artificial ventilation when I can no longer breathe on my own.

BBT Heart-regulating drugs, if my heartbeat becomes irregular.

BBT Nutrition and hydration other than ordinary food and water delivered by mouth, if I cannot eat and drink enough to sustain myself.

BBT Surgeries for the purpose of prolonging my life rather than for providing comfort.

BBT Dialysis if my kidneys do not work normally.

BBT Medications, treatments or procedures, when their primary purpose is to prolong life rather than control pain.

_____ Anything else intended to prolong my life.

7. MY WISHES CONCERNING COMFORT CARE AND PAIN MEDICATION

If I am experiencing symptoms such as pain, breathlessness, or visible discomfort, I want treatment to relieve my pain and symptoms and make me comfortable, even if medical providers believe this might unintentionally hasten my death, cause drug dependency, or make me unconscious.

Yes  No _____

8. IF A HEALTH CARE PROVIDER REFUSES TO HONOR MY DECISIONS OR DECISIONS OF MY HEALTH CARE AGENT

(Cross out this section, if you do not agree.)

If I am ever in a health care facility that refuses to honor my decisions expressed in this document or decisions made for me by my health care agent, I want my agent to take whatever actions he or she decides are appropriate to secure those decisions, including but not limited to changing my physician(s) or moving me out of the facility.

(Continued on next page)

9. MY WISHES CONCERNING OTHER MATTERS

	Yes	No
a. I consent to medical treatments that are experimental.	___	BSF
b. I want to donate organs/tissues.	___	BSF
c. I consent to an autopsy.	BSF	___
d. I consent to use of all or part of my body for medical education or research.	___	BSF
e. I have named the following individual(s) as my agent(s) for funeral arrangements:	___	BSF

My agent for funeral arrangements:

Name MONIQUE FEYRECILDE

Address 28641 SE 225TH ST., MAPLE VALLEY, WA 98038

Telephone ~~425~~ 425.221-1887

(day) (evening) (mobile)

My alternate agent for funeral arrangements (if my primary agent is unable or unwilling to serve, or if my agent is a spouse or partner from whom I am separated or divorced when decisions need to be made for me):

(optional)

Name

Address

Telephone

(day) (evening) (mobile)

f. I want my remains to be disposed of as follows (describe):

HUMAN COMPOSTING

10. IF A COURT APPOINTS A GUARDIAN FOR ME

If I have named a health care agent, I want my agent to be my guardian. If he/she cannot serve, then I want my alternate agent to be my guardian, if I have named an alternate. If the court decides to appoint someone else, I ask that the court require the guardian to consult with my agent (or alternate) concerning all health care decisions that would require my consent if I were acting for myself.

11. HOW THIS DIRECTIVE CAN BE REVOKED OR CANCELED

This directive can be revoked by a written statement to that effect, or by any other expression of intention to revoke. However, if I express disagreement with a particular decision made for me, that disagreement alone is not a revocation of this document. Note: The signed and witnessed or notarized Advance Directive with the latest date will take precedence over older Advance Directives.

12. SUMMARY AND SIGNATURE

I understand what this document means. If I am ever unable to make my own health care decisions, I am directing whoever makes them for me to do as I have said here. This includes withholding and/or withdrawing life-sustaining medical treatment, which might result in my death occurring sooner than if everything medically possible were done. I make this document of my free will, and I believe I have the mental and emotional capacity to do so. I want this document to become effective, even if I become incompetent or otherwise disabled.

(Sign only in the presence of two witnesses or in the presence of a notary.)

Signature _____ Date 260825

Bree Sadira Rose
Notary Public
State of Washington
My Appointment Expires 6/11/2027
Commission Number 208794

end of life
WASHINGTON
Your life. Your death. Your choice.

VALUES WORKSHEET

The following are questions you may want to consider as you make decisions and prepare documents concerning your health care preferences. You may want to write down your answers and provide copies to your family members and health care providers, or simply use the questions as "food for thought" and discussion.

How important to you are the following items?

	VERY IMPORTANT			NOT IMPORTANT	
Letting nature take its course. COMFORT CARE	4	(3)	2	1	0
Preserving quality of life.	(4)	3	2	1	0
Staying true to my spiritual beliefs/traditions	4	3	2	(1)	0
Living as long as possible, regardless of quality of life.	4	3	2	1	(0)
Being independent.	(4)	3	2	1	0
Being comfortable and as pain free as possible.	(4)	3	2	1	0
Leaving good memories for my family and friends.	(4)	3	2	1	0
Making a contribution to medical research or teaching.	4	3	2	1	(0)
Being able to relate to family and friends.	4	(3)	2	1	0
Being free of physical limitations.	4	(3)	2	1	0
Being mentally alert and competent.	4	(3)	2	1	0
Being able to leave money to family, friends, or charity.	4	3	2	(1)	0
Dying in a short while rather than lingering.	(4)	3	2	1	0
Avoiding expensive care.	(4)	3	2	1	0

What will be important to you when you are dying (e.g., physical comfort, no pain, family members present, etc.)?

PHYSICAL COMFORT, INDEPENDENCE, LACK OF PAIN

How do you feel about the use of life-sustaining measures in the face of terminal illness? Permanent coma? Irreversible chronic illness, such as Alzheimer's disease?

IF I AM NOT CONSIOUS ENOUGH TO RECOGNISE THAT SUCH MEASURES ARE BEING TAKEN, THEN I WOULD PREFER THEM NOT TO BE TAKEN

Do you have strong feelings about particular medical procedures? Some procedures to think about include mechanical breathing (respirator), cardiopulmonary resuscitation (CPR), artificial nutrition and hydration, hospital intensive care, pain relief medication, chemo or radiation therapy, and surgery.

NO NO NO YES NO CONDITIONALLY NO CONDITIONALLY NO

What limitations to your physical and mental health would affect the health care decisions you would make?

I DON'T KNOW

Would you want to have financial matters taken into account when treatment decisions are made?

YES!

Would you want to be placed in a nursing home if your condition warranted?

CONDITIONALLY NO

Would you prefer Hospice care, with the goal of keeping you comfortable in your home during the final period of your life, as an alternative to hospitalization?

CONDITIONALLY YES

In general, do you wish to participate or share in making decisions about your health care and treatment?

YES!

Would you always want to know the truth about your condition, treatment options, and the chance of success of treatments?

YES! IF I WERE CONSIOUS...