GUARDIAN'S ADVANCE DIRECTIVE FOR HEALTH CARE

Directive made this _____ day of _____, _____.
(month) (year)

I, as the legal guardian of _____, voluntarily make known my desire that the dying of my son/daughter/ward shall not be artificially prolonged under the circumstances set forth below, and do hereby declare that:

A. If, at any time, _____ should be diagnosed in writing to be in an advanced phase of a terminal condition by his or her attending physician, or in a permanent unconscious condition by two physicians, and if the application of life sustaining treatment would serve only to prolong artificially the process of his or her dying, I direct that such treatment be withheld or withdrawn, and that _____ be permitted to die naturally.

I understand by using this form that a terminal condition means an incurable and irreversible condition caused by injury, disease, or illness, that would, within reasonable medical judgement, 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 that a permanent unconscious condition means an incurable and irreversible condition in which _____ is medically assessed, within reasonable medical judgement, as having no reasonable probability of recovery from an irreversible coma or a persistent vegetative state.

B. If _____ is diagnosed to be in an advanced phase of a terminal condition or in a permanent unconscious condition *(initial & date selection):*

I ***do*** want him/her to have artificially provided nutrition
_____ *(initial)* _____ *(date)*
I ***do not*** want him/her to have artificially provided nutrition
_____ *(initial)* _____ *(date)*

C. If _____ is diagnosed to be in an advanced phase of a terminal condition or in a permanent unconscious condition *(initial & date selection)*:

I ***do*** want him/her to have artificially provided hydration
_____ *(initial)* _____ *(date)*
I ***do not*** want him/her to have artificially provided hydration
_____ *(initial)* _____ *(date)*

D. If _____ has been diagnosed as pregnant and that diagnosis is known to her physician, this Directive shall have no force or effect during the course of the pregnancy.

E. I understand the impact of this Directive, and am emotionally and mentally capable to make the health care decisions contained in this Directive on behalf of _____.

F. I understand that before I sign this Directive on behalf of _____, I can add to or delete from or otherwise change the wording of this Directive; that I may destroy, revoke or alter this Directive at any time; and that any 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 this Directive be implemented.

H. I make the following additional directions regarding the care of

_____:

_____
_____
_____
_____
_____
_____

Signed_____ Date_____

Print Name_____

Social Security Number _____

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

Witness _____

Witness _____

A witness must not be:

- related to the patient by blood or marriage;
- entitled to any portion of the estate of the patient upon the patient's death under any will of the patient or by the operation of law then existing;
- the attending physician or an employee of the attending physician or the health care facility in which the patient is admitted;
- a person who has a claim against any portion of the patient's estate upon the patient's death at the time of signing.