DISTRICT OF COLUMBIA ADVANCE DIRECTIVE
Durable Power of Attorney for Health Care, Living Will & Other Wishes

INSTRUCTIONS AND DEFINITIONS

Introduction: With this form, you can:

- Appoint someone to make medical decisions for you if you in the future are unable to make those decisions for yourself

and/or

- Indicate what medical treatment you do or do not want if in the future you are unable to make your wishes known.

Directions:

- Read each section carefully.
- Talk to the person you plan to appoint to make sure that he/she understands your wishes, and is willing to take the responsibility.
- Place the initials of your name in the blank before those choices you want to make.
- Fill in only those choices that you want under Parts 1, 2 and 3. Your advance directive should be valid for whatever part(s) you fill in, as long as it is properly signed.
- Add any special instructions in the blank spaces provided. You can write additional comments on a separate sheet of paper, but you should indicate on the form that there are additional pages to your advance directive.
- Sign the form and have it witnessed.
- Give your doctor, your nurse, the person you appoint to make your medical decisions for you, your family, and anyone else who might be involved in your care, a copy of your advance directive and discuss it with them.
- Understand that you may change or cancel this document at any time.

Words You Need to Know:

Advance Directive: A written document that tells what a person wants or does not want if he/she in the future can't make his/her wishes known about medical treatment.

Artificial Nutrition and Hydration: When food and water are fed to a person through a tube.

Autopsy: An examination done on a dead body to find the cause of death.

Comfort Care: Care that helps to keep a person comfortable but does not make him/her better. Bathing, turning, keeping a person's lips moist are types of comfort care.

CPR (Cardiopulmonary Resuscitation): Treatment to try and restart a person's breathing or heartbeat. CPR may be done by pushing on the chest, by putting a tube down the throat, or by other treatment.

Durable Power of Attorney for Health Care: An advance directive that appoints someone to make medical decisions for a person if in the future he/she can't make his/her own medical decisions.
Life-Sustaining Treatment: Any medical treatment that is used to keep a person from dying. A breathing machine, CPR, and artificial nutrition and hydration are examples of life-sustaining treatments.

Living Will: An advance directive that tells what medical treatment a person does or does not want if he/she is not able to make his/her wishes known.

Organ and Tissue Donation: When a person permits his/her organs (such as eyes or kidneys) and other parts of the body (such as skin) to be removed after death to be transplanted for use by another person or to be used for experimental purposes.

Persistent Vegetative State: When a person is unconscious with no hope of regaining consciousness even with medical treatment. The body may move and eyes may be open but as far as anyone can tell, the person can't think or respond.

Terminal Condition: An on-going condition caused by injury or illness that has no cure and from which doctors expect the person to die even with medical treatment Life-sustaining treatments will only prolong a person's dying if the person is suffering from a terminal condition.

DISTRICT OF COLUMBIA
ADVANCE DIRECTIVE

My Durable Power of Attorney for Health Care, Living Will and Other Wishes

I,_____, write this document as a directive regarding my medical care.

Put the initials of your name by the choices you want.

PART 1. MY DURABLE POWER OF ATTORNEY FOR HEALTH CARE.

As long as I can make my wishes known, my doctors will talk to me and I will make my own health care decisions. (Initial one of the choices below.)

_____ I appoint this person to make decisions about my medical care if there ever comes a time when I cannot make those decisions myself:

_____ _____
name home phone work phone cell phone

_____
address

If the person above cannot or will not make decisions for me, I appoint this person:

_____ _____
name home phone work phone cell phone

_____
address

OR

_____I have not appointed anyone to make health care decisions for me in this or any other document. I want the Person I have appointed, my doctors, my family, and others to be guided by the decisions I have made below:

PART 2. MY LIVING WILL

These are my wishes for my future medical care if there ever comes a time when I can't make these decisions for myself.

A. In general, these are the goals I have for my care if I am ever seriously ill or have a serious injury (state in your own words what you believe is most important to you):

_____
_____
_____
_____

Put the initials of your name next to important values for you if you are ever seriously ill or have a serious injury:

_____ Medicines needed to keep me pain-free
_____ Ability to recognize my family/friends
_____ other _____
_____ other _____

B. These are my wishes if I have a terminal condition:

Life-Sustaining Treatments

_____I do not want life-sustaining treatments (including CPR) started. If life-sustaining treatments are started, I want them stopped.

_____ I want life-sustaining treatments (including CPR) started on a temporary basis; if I do not show signs of recovery, then I want them stopped.

_____I want life-sustaining treatments that my doctors think are best for me.

Other wishes:_____

Artificial Nutrition and Hydration

_____I do not want artificial nutrition and hydration started if it would be the main treatment keeping me alive. If artificial nutrition and hydration is started, I want it stopped.

_____I want artificial nutrition and hydration, even if it is the main treatment keeping me alive.

_____Other wishes:_____

C. These are my wishes if I am ever in a persistent vegetative state:

Life-Sustaining Treatments

_____I do not want life-sustaining treatments (including CPR) started. If life-sustaining treatments are started, I want them stopped.
_____ I want life-sustaining treatments (including CPR) started on a temporary basis; if I do not show signs of recovery, then I want them stopped.
_____I want life-sustaining treatments that my doctors think are best for me.
_____Other wishes:_____

Artificial Nutrition and Hydration
_____I do not want artificial nutrition and hydration started if it would be the main treatment keeping me alive. If artificial nutrition and hydration is started, I want it stopped.
_____I want artificial nutrition and hydration, even if it is the main treatment keeping me alive.
_____Other wishes:_____

D. These are my wishes if I ever have an End-Stage Condition (including Alzheimer's or other dementia):

Life-Sustaining Treatments
_____ I do not want life-sustaining treatments (including CPR) started. If life-sustaining treatments are started, I want them stopped.
_____ I want life-sustaining treatments (including CPR) started on a temporary basis; if I do not show signs of recovery, then I want them stopped.
_____ I want life-sustaining treatments continued that my doctors think are best for me.

_____ Other wishes: _____

Artificial Nutrition and Hydration
_____I do not want artificial nutrition and hydration started if it would be the main treatment keeping me alive. If artificial nutrition and hydration is started, I want it stopped.
_____I want artificial nutrition and hydration, even if it is the main treatment keeping me alive.
_____Other wishes:_____

E. Other Directions
You have the right to be involved in all decisions about your medical care, even those not dealing with terminal conditions or persistent vegetative states. If you have wishes not covered in other parts of this document, please indicate them here._____
_____
_____

PART 3. OTHER WISHES.

A. Organ Donation
_____I do not wish to donate any of my organs or tissues.
_____I want to donate all of my organs and tissues.

_____I only want to donate these organs and tissues:
_____Other wishes: _____

B. Autopsy
_____I do not want an autopsy.
_____I agree to an autopsy if my doctors wish it
_____Other wishes: _____
If you wish to say more about any of the above choices, or if you have any other statements to make about your medical care, you may do so on a separate sheet of paper. If you do so, put here the number of pages you are adding:_____

PART 4. SIGNATURES

You and two witnesses must sign this document in order for it to be legal.
A. Your Signature
By my signature below I show that I understand the purpose and the effect of this document.
Signature: _____Date:_____

Address: _____

B. Your Witnesses' Signature

I believe the person who has signed this advance directive to be of sound mind, that he/she signed or acknowledged this advance directive in my presence, and that he/she appears not to be acting under pressure, duress, fraud, or undue influence. I am not related to the person making this advance directive by blood, marriage or adoption, nor, to the best of my knowledge, am I named in his/her will. I am not the person appointed in this advance directive. I am not a health care provider or an employee of health care provider who is now, or has been in the past, responsible for the care of the person making this advance directive.
Witness #1
Signature:_____ Date:_____

Address: _____
_____

Witness #2
Signature:_____ Date:_____

Address: _____
_____

DISCLAIMER: The law allows you to complete advance directives without the assistance of legal counsel. America Living Will Registry provides these advance directive forms as a service to you and does not take responsibility for the manner in which you complete them. If you have any questions about any part of these advance directive forms, be sure to consult an attorney before you sign them.