

Health Care Directive Of 醫療護理指示

[My Name]
[我的名字]

I am of sound mind and body and voluntarily execute this health care directive. If I cannot make decisions for myself about life sustaining medical treatment, my relatives, friends, agents and medical providers should fully honor every part of this directive. If any part of this directive is invalid, the remainder should be honored. I revoke any health care directives I have signed in the past.

我的身心健全，自願作出此醫療護理指示。在我不能為自己作出關於生命維持的醫療決定之時，我的親人、朋友、代理人和醫療服務提供者應該充分履行這項指示的每一部分。如果此指示的某一部分無效，餘下部分應該得到尊重並執行。我撤銷過去我已簽署了的任何醫療指示。

1. **Withhold or Withdraw Treatment.** If my attending physician diagnoses me with a **terminal condition**, or if two physicians determine that I am in a **permanent unconscious condition**, and if my physician(s) determine that life-sustaining treatment would only artificially prolong the process of dying, the following treatment should be withheld or withdrawn from me:

(check all that apply)

停止或撤銷治療。 如果我的主診醫生診斷出我處於**臨終狀態**，或者兩個醫生確定我處於**永久無意識狀態**，以及我的家庭醫生確定，維持生命的治療只會人為地延長死亡過程，請停止或撤銷對我的以下治療：

(請選擇所有適用選項)

- Artificial nutrition
人工營養
- Artificial hydration
人工水化
- Artificial respiration
人工呼吸

- Cardiopulmonary Resuscitation (CPR), including artificial ventilation, heart regulating drugs, diuretics, stimulants, or any other treatment for heart failure
心肺復蘇搶救 (CPR), 包括人工通氣、心率調節藥物、利尿劑、興奮劑或任何其他治療心衰藥物
- Surgery to prolong my life or keep me alive
延長我生命或者讓我活著的手術
- Blood dialysis or filtration for lost kidney function
為失去功能的腎作血透析或者進行過濾
- Blood transfusion to replace lost or contaminated blood
輸血以替換失去血液或受污染的血液
- Medication used to prolong life, not for controlling pain
用來延長壽命而不是用於控制疼痛的藥物
- Any other medical treatment used to prolong my life or keep me alive artificially
用來延長我的生命或人為地讓我活著的任何其他醫藥治療

2. **Comfort Care and Pain Medication.** If I appear to be experiencing pain or discomfort, I want treatment and medications to make me comfortable, even if my medical providers believe it might unintentionally hasten my death.

舒適護理和止痛藥。 在我感到正在疼痛中或者身體不適之時，我要求使用令我感到舒服的治療和藥物，即使我的醫療服務提供者認為這可能無意中加速我的死亡。

3. **Health Care Institutions.** If I am admitted to a hospital or other medical institution that will not honor this directive due to religious or other beliefs: (1) my consent to admission is not implied consent to treatment, and (2) I want to be transferred as soon as possible to a hospital or other medical institution that will honor my directive.

醫藥護理機構。 如果我被一家醫院或其他醫療機構接納進行治療，而這類治療並不尊重本人的宗教或其他信仰：（1）我同意被接納並不等於默示同意接受治療，以及（2）我要求儘快轉移到一家尊重我信仰的醫院或其他醫療機構。

4. **Changes and Revocation.** I understand that I can change the wording of this directive before I sign it. I also understand that I can revoke this directive at any time.

修改和撤銷。 我明白，在簽署之前我可以修改此指示的措辭。我也明白，我可以在任何時候撤銷本指示。

5. Health Care Values: The following wishes and preferences should guide all decisions made about my care:

醫療護理價值觀：以下願望和偏愛應該是所有有關我醫療護理決定的指示：

My Name / 我的姓名

My Date of Birth / 我的生日

Notarization

公證

State of Washington

County of _____

華盛頓州

_____ 郡縣

I certify that I know or have satisfactory evidence that _____, is the person who appeared before me, signed above, and acknowledged that the signing was done freely and voluntarily for the purposes mentioned in this instrument.

我證明，我知道或有令人滿意的證據表明，我面前的人 _____ 在此簽名，此人並承認，其為本文中提到目的而無所顧及地和自願地簽署了此文件。

Date 日期

Signature of Notary 公證員簽名

NOTARY PUBLIC for the State of Washington.

華盛頓州公證員

My commission expires _____.

我任職到期日為 _____

Statement of Witnesses (alternative)
證人陳述（供選擇）

On _____, the declarer of this document signed it in my presence. I believe the declarer is able to make health care decisions, to understand this document, and to have signed it voluntarily.

本文件的聲明人於 _____ 在我面前簽名。我相信聲明人理解本文件，能夠做出醫療保健決定，並自願簽署本文件。

- I am not related by blood or marriage to the declarer.
我與聲明人沒有血緣關係或婚姻關係。
- I am not now entitled to receive any portion of the declarer's estate, either by will or by operation of law, or as a result of any claim against the declarer.
我無權通過意願或法律程序，或通過向聲明人提出索償，而獲得聲明人財產的任何部分。

My Name / 我的姓名

My Date of Birth / 我的生日

- I am not the declarer's attending physician or an employee of that physician or of a health facility in which the declarer is a patient.
我不是聲明人的主治醫師，也不是聲明人作為患者而就醫的那位醫師或醫療機構的僱員。

Witness 1 證人之一

Witness 2 證人之二

Signature 簽名

Signature 簽名

Print Name 書寫姓名

Print Name 書寫姓名

Address 地址

Address 地址

Health Care Directive Contact Information

My name – first, middle, last 我的姓名 – 名、中間名、姓	
My date of birth 我的出生日期	My primary care medical provider 我的家庭醫生
My phone number 我的電話號碼	My email address 我的電子郵件信箱
My mailing address 我的郵寄地址	

- I have a Durable Power of Attorney form that lets someone else (my “agent”) make health care decisions for me if I am not able.
- 我有一份《持久授權書》，如果我無法做決定，其他人（我的“代理人”）可以為我做出醫療保健決定。

My health care agent’s name 我代理人的姓名	
My agent’s relationship to me (e.g. friend, partner, spouse, sister, etc.) 我代理人與我的關係（即，朋友、伴侶、配偶、姊妹，等等）	
My agent’s phone number 我代理人電話號碼	My agent’s email address 我代理人的電郵地址
My alternate health care agent’s name 我替代代理人的姓名	
My alternate agent’s relationship to me (e.g. friend, partner, spouse, sister, etc.) 我替代代理人與我的關係（即，朋友、伴侶、配偶、姊妹，等等）	
My alternate agent’s phone number 我替代代理人的電話號碼	My alternate agent’s email address 我替代代理人的電郵地址

My Name / 我的姓名

My Date of Birth / 我的生日