医疗保健指示书

我的姓名是_____。

我的出生日期是_____。

我具备决策能力。我自愿签署本指示书。如果无法自行做出决定，我的亲属、朋友、代理人和医务人员应充分遵重本指示书的每一部分。如果本指示书的任何部分无效，则应遵重本指示书的其余部分。我撤销以往签署的任何医疗服务指示书。

1. 医疗服务价值观：应遵循以下意愿和选择作出关于我的所有医疗决策：

a. 让我有生存价值的事项。

☐ 一些绝症或严重疾病可能让我**永远**无法从事保有生命价值的事情。这种情况下，如果我**再也不能**从事以下活动，那么除关怀护理、缓解疼痛和姑息治疗外，我希望终止所有治疗：

☐ 以任何有意义的方式认出我的亲友和家人

☐ 锻炼

☐ 户外活动

☐ 阅读

☐ 看电视/电影

从事以下活动：

_____

_____

_____

_____

Health Care Directive

My name is _____.

My birth date is _____.

I am a person with decision-making capacity. I voluntarily sign this directive. If I cannot make decisions for myself, my relatives, friends, agents, and medical providers should fully honor every part of this directive. If any part of this directive is invalid, the rest should be honored. I revoke any health care directives I have signed in the past.

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

a. What makes my life worth living.

Some terminal or serious conditions may stop me from **ever** doing the things that make life worth living for me. In that situation, I want you to stop all treatment except comfort care, pain relief and palliative care if I **cannot ever again**:

Recognize my close friends and family in any meaningful way

Exercise

Be outdoors

Read

Watch tv shows/movies

Do the following:

_____

_____

_____

_____

☐ 其他：

_____

_____

_____

☐ 始终保有生命价值。尽可能维持生命。

b. 我的希望。在最后时光里，我希望：

☐ 与我的亲密朋友和家人在一起：

_____

☐ 与以下慰藉物品和/或宠物在一起：

_____

☐ 食用/饮用以下物品（如可能）：

_____

☐ 听以下音乐：

_____

☐ 其他：

_____

_____

c. 疼痛管控。治疗疼痛的药物通常伴有嗜睡和头脑不清的副作用。在最后时光里，我希望采用以下方式在镇痛的同时能够保持头脑清晰：

☐ 我希望尽可能减少疼痛，即使神智不清也无妨。

☐ 我愿意在头脑比较清醒的情况下忍受以下程度的疼痛：

Other:

_____

_____

_____

Life is always worth living. Do everything you can to keep me alive.

b. My hopes. In my last days, I hope to spend my time:

With my close friends and family:

_____

With the following comfort items and/or pets:

_____

Eating/drinking the following items, if possible:

_____

Listening to the following music:

_____

Other:

_____

_____

c. Pain Management. Medications used to treat pain often come with the side effect of drowsiness and decreased mental clarity. In my last days, I hope to balance pain management and mental clarity in this way:

I hope to spend my time in as little pain as possible, even if I’m not mentally clear.

I am willing to tolerate the following level of pain in the hopes of having more mental clarity:

☐ 1 =几乎没有注意到的疼痛

☐ 2 =感到疼痛，但不干扰任何活动

☐ 3 =有时会因疼痛分散注意力

☐ 4 =会因疼痛分散注意力，但可以从事日常活动

☐ 5 =因疼痛而中止一些活动

☐ 6 =无法忽视的疼痛，需要避免日常活动

☐ 7 =疼痛成为关注焦点，并妨碍日常活动

☐ 8 =疼痛剧烈，难以从事任何事情

☐ 9 =疼痛无法忍受，无法从事任何事情

☐10 =所能想象的最剧烈疼痛。务必保持最大限度的头脑清醒。

1 = Pain I hardly notice

2 = Pain I notice but does not interfere with activities

3 = Pain that sometimes distracts me

4 = Pain that distracts me, but I can do usual activities

5 = Pain interrupts some activities

6 = Pain is hard to ignore, I avoid usual activities

7 = Pain is my focus of attention, prevents daily activities

8 = Pain is awful, it's hard to do anything

9 = Pain is unbearable, I'm unable to do anything

10 = Pain as severe as I can imagine. Maximum mental clarity is the most important.

d. 我的恐惧。我对一些情况或治疗心存芥蒂，并希望进行预防或避免（如有可能）。

d. My fears. There are situations or treatments I am concerned about and want to prevent or avoid if possible.

☐ 我害怕（例如:呼吸困难、口渴、窒息感、恶心、头痛）：

_____

。

请尽一切可能通过关怀护理缓解这种感觉。

I have a fear of (examples: shortness of breath, thirst, choking sensation, nausea, headaches):

_____.

Please do everything possible to relieve me of that feeling through comfort care.

☐ 我不希望在疾病晚期使用救生措施。请为我的临终治疗提供成本最低的关怀护理。

I don’t want to spend our life savings on my final illness. Please provide the least costly comfort care for my end-of-life care.

☐ 其他：_____

_____

_____

Other: _____

_____

_____

e. 我希望待在哪里？如有可能，我希望在以下地点接受护理：

- ☐ 家里
- ☐ 临终关怀机构
- ☐ 辅助生活机构
- ☐ 成人家庭之家
- ☐ 疗养院
- ☐ 医院
- ☐ 我知道，鉴于当时的需求和客观条件，我可能无法在希望的地点获得护理。我相信我的医疗决策者，并知道他们会在考虑我的价值观并咨询我的亲人和医护人员后为我做出最佳决策。
- ☐ 其他：_____

_____

_____

f. 有关我的其他事项:

- ☐ 我希望我的朋友和家人知悉我的病情，并有机会跟我道别。
- ☐ 如果需要，我希望能短时间延长生命，让朋友和家人有时间远道赶来道别。
- ☐ 如有可能，我希望在弥留之际能够看到窗外风景或者看到大自然。

e. Where I want to be. I would like to receive care in the following place/s if possible:

- ☐ My home
- ☐ Hospice care
- ☐ An assisted living facility
- ☐ An adult family home
- ☐ A nursing home
- ☐ A hospital
- ☐ I know that it may not be possible for me to receive care where I want, given my needs and circumstances at the time. I trust my healthcare decision-maker/s and know that they will make the best decisions for me after considering my values, and consulting with my loved ones and care providers.
- ☐ Other: _____

_____

_____

f. Other things to know about me:

- ☐ I would like my friends and family to be notified of my condition and given an opportunity to visit me to say goodbye.
- ☐ I would like to be kept alive for a short period of time if needed to allow friends and family time to travel and say goodbye.
- ☐ If possible, I would like to be able to look out a window or see nature during my last days.

☐ 我的宗教或文化传统要求采取以下做法提供医疗服务和临终关怀：

_____

_____

_____

☐ 其他：_____

_____

_____

_____

_____

_____

My religious or cultural traditions require the following practices around health care and end of life care:

_____

_____

_____

Other: _____

_____

_____

_____

_____

_____

2. 疾病终末期或永久性昏迷状态。如果主治医生诊断我处于疾病终末期，或者两名医生认定我处于永久性昏迷状态，而且医生认定生命维持治疗只会人为延长死亡过程时，我希望：

2. Terminal Illness or Permanent Unconscious Condition. If my attending physician diagnoses me with a terminal condition or 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, I want:

a. 关怀护理和止痛药物。（*请勾选一项*）

a. Comfort Care and Pain Medication. (*check one*)

☐ 如果我看起来正在经历疼痛或痛苦，我希望接受一些让我感到舒服的治疗和药物，即使医疗人员认为这样作可能会在无意中加速死亡。

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.

☐ 如果一些治疗和药物可能加速死亡，则我不希望接受这些让我感觉舒服的治疗和药物。即使感到疼痛，也要尽一切可能活下去。请使用,不会加速死亡的疼痛管控方法。

I don't want treatment and medications to make me comfortable if those treatments and medications might hasten my death. Do everything possible to keep me alive even if I am in pain. Please use pain management methods that will not hasten my death.

b. 人工生命维持（*请勾选一项*）

b. Artificial Life Support. (*check one*)

☐ 请使用所有治疗选项人为延长死亡过程，或者维持一种永久无意识状态。

☐ Please use all treatment options to artificially prolong the process of dying or sustain me in a permanent unconscious condition.

☐ 应在（时限）之后**拒绝**或**撤销**以下治疗措施 _____（*请勾选所有适用*项）：

☐ The following treatment should be **withheld** or **withdrawn** from me after (*period of time*) _____ (*check all that apply*):

☐ 人工营养

☐ Artificial nutrition

☐ 人工补水

☐ Artificial hydration

☐ 人工呼吸（呼吸机）

☐ Artificial respiration (ventilator)

☐ 心肺复苏（CPR），包括人工通气、心脏调节药物、利尿剂、兴奋剂，或任何其他心力衰竭治疗措施

☐ Cardiopulmonary Resuscitation (CPR), including artificial ventilation, heart regulating drugs, diuretics, stimulants, or any other treatment for heart failure

☐ 通过手术延长生命或者维持生命

☐ Surgery to prolong my life or keep me alive

☐ 因丧失肾功能而进行的血液透析或过滤

☐ Blood dialysis or filtration for lost kidney function

☐ 输血以补充失血或替换受污染的血液

☐ Blood transfusion to replace lost or contaminated blood

☐ 通过药物延长生命，而不是镇痛

☐ Medication used to prolong life, not for controlling pain

☐ 用来延长生命或者人工维持生命的任何其他医疗措施

☐ Any other medical treatment used to prolong my life or keep me alive artificially

3.死后事项

3. After Death

a. 器官、部分身体和组织

a. Organs, body parts, and tissues

☐ 我希望捐赠器官、部分身体和组织。（*如果有，请具体说明*）：

_____

_____

_____

☐ I want to donate organs, body parts, and tissues. (*Specific instructions, if any*):

_____

_____

_____

☐ 我不希望捐赠器官、部分身体和组织。

b. 医学教育或研究

☐ 我同意将全部或部分身体用于医学教育或研究。

☐ 我**不**同意将全部或部分身体用于医学教育或研究。

c. 尸检

☐ 我同意接受尸检。

☐ 我**不**同意接受尸检。

d. 返还尸体和遗骸

☐ 去世后，可以将我的尸体和遗骸返还给以下人员：（*姓名和联系信息*）：

_____

_____

_____

_____

_____

4. 医疗服务机构。如果住院或入住其他医疗机构时，这些机构因宗教或其他信仰无法遵重本指示书：（1）我同意入院，但并不默认同意接受治疗；以及（2）我希望尽快转院到能够遵重本医疗指示书的医院或其他医疗机构。

I don't want to donate organs, body parts, and tissues.

b. Medical education or research

I consent to use all or part of my body for medical education or research.

I **don't** consent to use all or part of my body for medical education or research.

c. Autopsy

I consent to an autopsy.

I **don't** consent to an autopsy.

d. Releasing my body and remains

Upon my death, my body and remains can be released to the following person/s: (*Name/s and contact information*):

_____

_____

_____

_____

_____

4. 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.

5. 更改和取消。我知道，签署本指示书之前，我可以更改指示书措辞。我还知道，我可以随时取消本指示书。	**5. Changes and Cancellation.** I understand that I can change the wording of this directive before I sign it. I also understand that I can cancel this directive at any time.

日期：_____	← Date
▶ _____ 本人签名（在公证员或见证人面前）	← My signature (in front of a notary or witnesses)

Notarization (preferred)（*公证（首选）*）

State of Washington *（Washington 州）*
County of *（所在郡县）*_____

Signed or attested before me on (*date*)_____
(于此()日期)在我的面前签名或证明，
by (*name*) / (人员*（姓名）*_____。

▶ _____
Signature of Notary *（公证人签名）*

Notary Public for the State of Washington.
（Washington 州公证员。）

My commission expires *（公证职责截止日期）*

_____

证人声明（仅适用于无法找到公证人时）	**Statement of Witnesses (only if you cannot find a notary)**
*（姓名）*_____，于(*日期*)_____，在本人在场的情况下签署了本医疗保健指示书。其本人认识我，或者获取了我的身份证明。我相信其具备医疗决策能力。	On (*date*) _____, (*name*) _____ signed this Health Care Directive in my presence. They are personally known to me or provided proof of identity. I believe they are capable of making health care decisions.
▪ 我与此人没有任何血缘关系或婚姻关系。	▪ I am not related to this person by blood or marriage.

- 我没有资格继承此人的任何金钱或财产。
- 我从未对此人提出过法律索赔。
- 我不是此人的主治医生。我并非对此人进行治疗的医生或医疗机构的雇员。

- I am not eligible to inherit money or property from this person.
- I do not have a legal claim against this person.
- I am not this person's attending physician. I am not an employee of their physician, or of any health facility where they are a patient.

见证人 1

Witness 1

▶ _____ ← Signature

签名

_____ ← Print name

正楷体姓名

地址 _____ ← Address

_____

电话 _____ ← Phone

见证人 2

Witness 2

▶ _____ ← Signature

签名

_____ ← Print name

正楷体姓名

地址 _____ ← Address

_____

电话 _____ ← Phone

医疗保健指示书附件：联系信息

Health Care Directive Attachment: Contact Info

我的信息

My information

我的姓名 _____

My name

我的出生日期 _____

My date of birth

我的电话号码 _____

My phone number

我的电子邮箱 _____

My email address

我的邮寄地址 _____

_____

My mailing address

我的初级保健医生_____

My primary care medical provider

授权书

Power of attorney

☐ 我签署过一份**《持久性授权书》**，可以让其他人（我的“代理人”）在我失能时为我作出医疗决策。

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.

我的医疗决策代理人（如果有）

My health care agent (if any)

姓名 _____

Name

与我的关系（例如朋友、伴侣、配偶、姐妹等）

_____

Relationship to me (Examples: friend, partner, spouse, sister, etc.)

电话 _____

Phone

电子邮箱 _____

Email

我的医疗决策候补代理人（如果有）

My alternate health care agent (if any)

姓名 _____

Name

与我的关系（例如朋友、伴侣、配偶、姐妹等）

_____

Relationship to me (Examples: friend, partner, spouse, sister, etc.)

电话 _____

Phone

电子邮箱 _____

Email

我的第 2 名医疗决策候补代理人（如果有）

姓名 _____

与我的关系（例如朋友、伴侣、配偶、姐妹等）

_____

电话 _____

电子邮箱 _____

My 2nd alternate health care agent (if any)

Name

Relationship to me (Examples: friend, partner, spouse, sister, etc.)

Phone

Email

其他事先规划

我有与事先规划或生命末期有关的以下其他文件（*文档列表*）：

_____

_____

_____

_____

_____

Other advance planning

I have the following other documents about advance planning or end-of-life (*list document/s*):

_____

_____

_____

_____

_____