

# **Advance Directives for Health Care**

*Planning Ahead for Important  
Health Care Decisions*



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*The following organizations and institutions have endorsed this brochure:*

- American Association of Retired Persons
- American College of Physicians (N.J. Chapter)
- American Jewish Congress
- Citizens Committee on Biomedical Ethics
- Committee on Bioethics of the Union of American Hebrew Synagogues
- Episcopal Diocese of Newark
- Federation of Reformed Synagogues of Greater Philadelphia (South Jersey)
- Home Care Council of New Jersey
- Medford Leas Retirement Community
- Medical and Dental Staff of the Medical Center at Princeton
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- New Jersey Association of Health Care Facilities
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- Overlook Hospital Bioethics Committee
- Older Women's League (Central New Jersey)
- Pennsylvania Council of the Union of American Hebrew Congregations
- Robert Wood Johnson University Hospital
- University of Medicine and Dentistry of New Jersey

This brochure is a publication of the **State of New Jersey Commission of Legal and Ethical Problems in the Delivery of Health Care (The New Jersey Bioethics Commission)**.



## State of New Jersey

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CHAIRMAN

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EXECUTIVE DIRECTOR

**SISTER JANE FRANCES BRADY**  
VICE-CHAIRMAN

Dear New Jersey Citizen,

This booklet was prepared by the New Jersey Commission on Legal and Ethical Problems in the Delivery of Health Care and its Task Force on Public and Professional Education. Its purpose is to help you to plan ahead for important health care decisions by utilizing documents known as advance directives for health care, more commonly known as “living wills” and “durable powers of attorney for health care”.

Advance directives are legally recognized documents which may have important consequences for your future health care. *It is important that you read all of the material in this booklet carefully before completing your directive.* It is designed to help you prepare a directive which clearly reflects your medical treatment preferences. In addition to basic information on advance directives, the booklet includes 3 sample advance directive forms and a description of the advantages and disadvantages of each one. You should use whichever form best suits your personal needs.

Understandably, the subjects of death, dying and our own incapacity are difficult to discuss with others. Nonetheless, we at the Commission feel strongly that it is especially important to discuss your feelings and beliefs about these subjects with those who may become responsible for making decisions for you, such as family members, friends and your physician. Advance directives provide an important written statement of your wishes to others, but direct communication is the key to insuring that those wishes are clearly understood by others. Candid conversation can significantly reduce the chances of disagreements among those who care for you, may relieve your loved ones of some of the heavy burdens of decision making, and lend additional assurance that your wishes will be respected.

You do not need an attorney or a physician to complete a directive, although you should consult one if you wish. Make sure to have your directive witnessed by two adults (if you choose to legally designate a person to make decisions for you, he or she cannot also be a witness). Give copies of the completed form to those who should know about your preferences, such as family members, friends and your doctor. If you enter a hospital or nursing home make sure your directive is made part of your medical records.

The Commission would like to express its gratitude to the prestigious organizations and institutions who have supported us in the production of this brochure. We also thank you for your interest in the Commission along with our hope that the enclosed information is helpful to you and your family.

Sincerely,

A handwritten signature in cursive script that reads "Paul W. Armstrong".

(P. W. Armstrong)  
Chairman

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The materials and forms included in this brochure were written and prepared by Robert S. Olick, M.A., J.D., Executive Director, Mihael Vollen, Associate Director (Project Director), and members of the Task Force. The following former staff members provided additional advice and support: Jancie Chiantese, Director of Government Relations (co-Project Director), Adrienne Asch, Associate in Social Science and Policy, Anne Reichman, LL.B, LL.M, Associate in Law, Eve B. Sundelson, Esq., consultant, Ellen Friedlan, Esq., consultant. The Commission wishes to express its gratitude to all these individuals for their contributions.

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# Planning Ahead For Your Health Care: Making Your Wishes Known

The purpose of this brochure is to help you prepare an advance directive which reflects your wishes concerning medical care. While it contains sample forms and directions, advance directives are very personal documents and you should feel free to develop one which best suits your own needs. The brochure consists of the following parts:

1. Introduction
2. Questions and Answers
3. Terms You Should Understand
4. Sample Forms
5. Checklist
6. Wallet size I.D. cards (inside back cover)

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## 1. Introduction: Why this booklet?

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As Americans, we take it for granted that we are entitled to make decisions about our own health care. Most of the time we make these decisions after talking with our own physician about the advantages and disadvantages of various treatment options. The right of a competent individual to accept or refuse medical treatment is a fundamental right protected by law.

But what happens if serious illness, injury or permanent loss of mental capacity makes us incapable of talking to a doctor and deciding what medical treatments we do or do not want? These situations pose difficult questions to all of us as patients, family members, friends and health care professionals. Who makes these decisions if we can't make them for ourselves? If we can't make our preferences known how can we make sure that our wishes will be respected? If disagreements arise among those caring for us about different treatment alternatives how will they be resolved? Is there a way to alleviate the burdens shouldered by family members and loved ones when critical medical decisions must be made?

By using documents known as **advance directives for health care**, you can answer some of these questions and give yourself the security of knowing that you can continue to have a say in your own treatment. A properly prepared **advance**

**directive** permits you to plan ahead so you can both make your wishes known, and select someone who will see to it that your wishes are followed.

After all, if you are seriously ill or injured and can't make decisions for yourself someone will have to decide about your medical care. Doesn't it make sense to

- Have a person you trust make decisions for you, or
- Provide instructions about the treatment you do and do not want, or
- Both. Appoint a person to make decisions **and** provide them with instructions.

### A Few Definitions

Throughout this booklet we're going to use four phrases. Each of these phrases has a special meaning when it comes to allowing you to make decisions about your future health care.

- **Advance directive** - If you want your wishes to guide those responsible for your care you have to plan for what you want in advance. Generally such planning is more likely to be effective if it's done in writing. So, by an "advance directive" we mean any written directions you prepare in advance to say what kind of medical care you want in the event you become unable to make decisions for yourself.

There are three kinds of advance directives:

1. **Proxy directives** -- One way to have a say in your future medical care is to designate a person (a proxy) you trust and give that person the legal authority to decide for you if you are unable to make decisions for yourself. Your chosen proxy (known as a **health care representative**) serves as your substitute, "standing in" for you in discussions with your physician and others responsible for your care. So, by a **proxy directive** we mean written directions that name a "proxy" to act for you. Another term some people use for a proxy directive is a "durable power of attorney for health care".

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2. **Instruction directives** -- Another way to have a say in your future medical care is to provide those responsible for your care with a statement of your medical treatment preferences. By “**instruction directive**” we mean written directions that spell out in advance what medical treatments you wish to accept or refuse and the circumstances in which you want your wishes implemented. These instructions then serve as a guide to those responsible for your care. Another term some people use for an instruction directive is a “living will”.

3. **Combined directives** -- A third way combines features of both the **proxy** and the **instruction directive**. You may prefer to give both written instructions, and to designate a health care representative or proxy to see that your instructions are carried out. So, by a “**combined directive**” we mean a single document in which you select a health care representative and provide him or her with a statement of your medical treatment preferences.

Whichever form you choose, it is important to remember to discuss your health care preferences with others. In order to help you choose the kind of directive which best suits your circumstances, the following pages answer some frequently asked questions about advance directives.

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## 2. Questions and Answers

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### **Why should I consider writing an advance directive?**

Serious injury, illness or mental incapacity may make it impossible for you to make health care decisions for yourself. In these situations, those responsible for your care will have to make decisions for you. Advance directives are legal documents which provide information about your treatment preferences to those caring for you, helping to insure that your wishes are respected even when you can't make decisions yourself. A clearly written directive helps prevent disagreements among those close to you and alleviates some of the burdens of decision making which are often experienced by family members, friends and health care providers.

### **When does my advance directive take effect?**

Your directive takes effect when you no longer have the ability to make decisions about your health care. This judgment is normally made by your attending physician, and any additional physicians who may be required by law to examine you. If there is any doubt about your ability to make such decisions, your doctor will consult with another doctor with training and experience in this area. Together they will decide if you are unable to make your own health care decisions.

### **What happens if I regain the ability to make my own decisions?**

If you regain your ability to make decisions, then you resume making your own decisions directly. Your directive is in effect only as long as you are unable to make your own decisions.

### **What is the advantage of having a health care representative, isn't it enough to have an instruction directive?**

Your doctor and other health care professionals are legally obligated to consider your expressed wishes as stated in your **instruction directive** or “living will”. However, instances may occur in which medical circumstances arise or treatments are proposed that you may not have thought about when you wrote your directive. If this happens your **health care representative** has the authority to participate in discussions with your health care providers and to make treatment decisions for you in accordance with what he or she knows of your wishes. Your health care representative will also be able to make decisions as your medical condition changes, in accordance with your wishes and best interests.

### **If I decide to appoint a health care representative, who should I trust with this task?**

The person you choose to be your health care representative has the legal right to accept or refuse medical treatment (including life-sustaining measures) on your behalf and to assure that your wishes concerning your medical treatment are carried out. You should choose a person who knows

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you well, and who is familiar with your feelings about different types of medical treatment and the conditions under which you would choose to accept or refuse either a specific treatment or all treatment.

A health care representative must understand that his or her responsibility is to implement your wishes even if your representative or others might disagree with them. So it is important to select someone in whose judgment you have confidence. People that you might consider asking to be your health care representative include:

- a member of your family or a very close friend, your priest, rabbi, or minister, or
- a trusted health care provider, but your attending physician cannot serve as both your physician and your health care representative.

### **Should I discuss my wishes with my health care representative and others?**

Absolutely! Your health care representative is the person who speaks for you when you can't speak for yourself. It is very important that he or she has a clear sense of your feelings, attitudes and health care preferences. You should also discuss your wishes with your physician, family members and others who will be involved in caring for you.

### **Does my health care representative have the authority to make all health care decisions for me?**

It is up to you to say what your health care representative can and cannot decide. You may wish to give him or her broad authority to make all treatment decisions including decisions to forego life-sustaining measures. On the other hand, you may wish to restrict the authority to specific treatments or circumstances. Your representative has to respect these limitations.

### **Is my doctor obligated to talk to my health care representative?**

Yes. Your health care representative has the legal authority to make medical decisions on your behalf, in consultation with your doctor. Your doctor is legally obligated to consult with your

chosen representative and to respect his or her decision as if it were your decision.

### **Is my health care representative the only person who can speak for me, or can other friends or family members participate in making treatment decisions?**

It is generally a good idea for your health care representative to consult with family members or others in making decisions, and if you wish you can direct that he or she do so. It should be understood by everyone, however, that your health care representative is the only person with the legal authority to make decisions about your health care even if others disagree.

### **If I want to give specific instructions about my medical care, what should I say?**

If you have any special concerns about particular treatments you should clearly express them in your directive. If you feel there are medical conditions which would lead you to decide to forego all medical treatment, including life-sustaining measures, and accept an earlier death, this should be clearly indicated in your directive.

### **Are there particular treatments I should specifically mention in my directive?**

It is a good idea to indicate your specific preferences concerning two specific kinds of life-sustaining measures: artificially provided fluids and nutrition and cardiopulmonary resuscitation. Stating your preferences clearly concerning these two treatments will be of considerable help in avoiding uncertainty, disagreements or confusion about your wishes. The enclosed forms provide a space for you to state specific directions concerning your wishes with respect to these two forms of treatment.

### **Can I request all measures be taken to sustain my life?**

Yes. You should make this choice clear in your advance directive. Remember, a directive can be used to request medical treatments as well as to refuse unwanted ones.

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**Does my doctor have to carry out my wishes as stated in my instruction directive?**

If your treatment preferences are clear your doctor is legally obligated to implement your wishes, unless doing this would violate his or her conscience or accepted medical practice. If your doctor is unwilling to honor your wishes he or she must assist in transferring you to the care of another doctor.

**Can I make changes in my directive?**

Yes. An advance directive can be updated or modified, in whole or in part, at any time, by a legally competent individual. You should update your directive whenever you feel it no longer accurately reflects your wishes. It is a good idea to review your directive on a regular basis, perhaps every 5 years. Each time you review the directive, indicate the date on the form itself and have someone witness the changes you make. If you make a lot of changes, you may want to write a new directive. Remember to notify all those important to you of any changes you make.

**Can I revoke my directive at any time?**

Yes. You can revoke your directive at any time, regardless of your physical or mental condition. This can be done in writing, orally, or by any action which indicates that you no longer want the directive to be in effect.

**Who should have copies of my advance directive?**

A copy should be given to the person that you named as your health care representative, as well as to your family, your doctor, and others who are important to you. If you enter a hospital, nursing home, or hospice, a copy of your advance directive should be provided so that it can be made part of your medical records. The back cover of this brochure contains a wallet size card you can complete and carry with you to tell others that you have an advance directive.

**Can I be required to sign an advance directive?**

No. An advance directive is not required for admission to a hospital, nursing home, or other health care facility. You cannot be refused

admission to a hospital, nursing home, or other health care facility because you do not have an advance directive.

**Can I be required to complete an advance directive as a condition of my insurance coverage?**

No. You cannot be required to complete an advance directive as a condition for obtaining a life or health insurance policy. Also, having, or not having, an advance directive has no effect on your current health or life insurance coverage, or health benefits.

**Can I use my advance directive to make an organ donation upon my death?**

Yes. The sample combined directive and instruction directive included with this brochure provide a place for you to state your wishes regarding organ donation. Also, on the inside back cover of this brochure is a wallet size organ donor card. If you decide to make a gift of your organs upon your death please complete the card and carry it with you at all times. For further information regarding organ donation you should contact either an organ procurement agency or your local hospital.

**Will another state honor my advance directive?**

It is likely that your advance directive will be honored in another state, but this is not guaranteed.

**What if I already have a living will?**

While you may want to review your existing living will or advance directive and make sure it reflects your wishes, there is no legal requirement that you do so.

**Do I need an attorney or a doctor to write one?**

You should consult with anyone you think can be helpful, but it is not necessary. This booklet and the forms which are included are designed to enable you to complete your advance directive without the need for legal or medical advice. If the medical terminology is unclear to you, most health care professionals will be able to help you understand it.

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### 3. Terms You Should Understand

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1. **Artificially provided fluids and nutrition:** The provision of food and water to seriously ill patients who are unable or unwilling to eat. Depending on the method used, such as insertion of a feeding tube or an intravenous line, and the condition of the patient, techniques may involve minor surgery, continuous supervision by medical (and sometimes surgical) personnel, risk of injury or infection, and side effects.

2. **Cardiopulmonary Resuscitation (CPR):** A treatment administered by health care professionals when a person's heartbeat and breathing stops. CPR may restore functioning if administered properly and in a timely fashion and may include the use of mechanical devices and/or drugs.

3. **Life-sustaining measures:** Any medical procedure, device, artificially provided fluids and nutrition, drugs, surgery, or therapy that uses mechanical or other artificial means to sustain, restore or supplant a vital bodily function, thereby prolonging the life of a patient.

4. **Decision making capacity:** A patient's ability to understand the benefits and risks of a proposed medical treatment and its alternatives and to reach an informed decision.

5. **Health care representative or health care proxy:** In the event an individual loses decision making capacity, a health care representative or proxy is a person who has been legally designated to make decisions on his or her behalf. A health care representative is appointed through the execution of a proxy directive (a durable power of attorney for health care).

6. **Terminal condition:** The terminal stage of an irreversibly fatal illness, disease, or condition. While determination of a specific "life expectancy" is not required for a diagnosis of a "terminal condition", a prognosis of a life expectancy of one year or less, with or without the provision of life-

sustaining treatment, is generally considered terminal.

7. **Permanent unconsciousness:** A medical condition defined as total and irreversible loss of consciousness. The term "permanently unconscious" includes the conditions persistent vegetative state and irreversible coma. Patients in this condition cannot interact with their surroundings or others in any way and do not experience pleasure or pain.

8. **Persistent vegetative state:** A condition of permanent unconsciousness in which the patient loses all capacity for interaction with their environment or other people. It is usually caused by an injury to the brain. It is normally not regarded as a terminal condition and with the aid of medical care and artificial fluids and nutrition patients can survive for many years.

9. **Incurable and irreversible chronic diseases:** Disabling diseases such as Alzheimer's diseases, organic brain syndrome or other diseases which get progressively worse over time, eventually resulting in death. Depending on the disease, the patient may also experience partial or complete loss of physical and mental abilities. Because the rate at which these diseases advance may be slow, such diseases are not considered terminal in their early stages.

10. **Whole brain death:** Death due to total and irreversible loss of all functions of the entire brain, including the brain stem. The criteria of whole brain death must be used to accurately determine death in individuals who have suffered massive or total brain damage but whose heart and lungs are kept functioning by machines. Brain dead individuals are not vegetative or in a coma, but are, in fact, dead.

11. **Attending physician:** The doctor directly responsible for your medical treatment. He or she may or may not be your regular family physician. Depending on your health care needs the attending physician may consult with others in order to diagnose and treat your medical condition, but he or she remains directly responsible for your care.



**PROXY DIRECTIVE--(Durable Power of Attorney for Health Care)  
Designation of Health Care Representative**

I understand that as a competent adult, I have the right to make decisions about my health care. There may come a time when I am unable, due to physical or mental incapacity, to make my own health care decision. In these circumstances, those caring for me will need direction and they will turn to someone who knows my values and health care wishes. By writing this durable power of attorney for health care I appoint a health care representative with the legal authority to make health care decisions on my behalf and to consult with my physician and others. I direct that this document become part of my permanent medical records.

**A) CHOOSING A HEALTH CARE REPRESENTATIVE:**

I, \_\_\_\_\_, hereby designate \_\_\_\_\_,  
of \_\_\_\_\_

\_\_\_\_\_  
**(home address and telephone number of health care representative)**

as my health care representative to make any and all health care decisions for me, including decisions to accept or to refuse any treatment, service or procedure used to diagnose or treat my physical or mental condition and decisions to provide, withhold or withdraw life-sustaining measures. I direct my representative to make decisions on my behalf in accordance with my wishes as stated in this document, or as otherwise known to him or her. In the event my wishes are not clear, my representative is authorized to make decisions in my best interest, based on what is known of my wishes.

This durable power of attorney for health care shall take effect in the event I become unable to make my own health care decisions, as determined by the physician who has primary responsibility for my care, and any necessary confirming determinations.

**B) ALTERNATE REPRESENTATIVES:** If the person I have designated above is unable, unwilling or unavailable to act as my health care representative, I hereby designate the following person(s) to act as my health care representative, in the order of priority stated:

- |                        |                        |
|------------------------|------------------------|
| 1. name _____          | 2. name _____          |
| address _____          | address _____          |
| city _____ state _____ | city _____ state _____ |
| telephone _____        | telephone _____        |

**C) SPECIFIC DIRECTIONS: Please initial the statement below which best expresses your wishes.**

\_\_\_\_\_ My health care representative is authorized to direct that artificially provided fluids and nutrition, such as by feeding tube or intravenous infusion, be withheld or withdrawn.

\_\_\_\_\_ My health care representative does not have this authority, and I direct that artificially provided fluids and nutrition be provided to preserve my life, to the extent medically appropriate.

**The New Jersey Commission on Legal and Ethical Problems in the Delivery of Health Care**

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(If you have any additional specific instructions concerning your care you may use the space below or attach an additional statement.)

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**D) COPIES:** The original or a copy of this document has been given to my health care representative and to the following:

1. name \_\_\_\_\_  
address \_\_\_\_\_  
city \_\_\_\_\_ state \_\_\_\_\_ telephone \_\_\_\_\_
2. name \_\_\_\_\_  
address \_\_\_\_\_  
city \_\_\_\_\_ state \_\_\_\_\_ telephone \_\_\_\_\_

**E) SIGNATURE:** By writing this durable power of attorney for health care, I inform those who may become entrusted with my care of my health care wishes and intend to ease the burdens of decision making which this responsibility may impose. I have discussed the terms of this designation with my health care representative and he or she has willingly agreed to accept the responsibility for acting on my behalf in accordance with my wishes as expressed in this document. I understand the purpose and effect of this document and sign it knowingly, voluntarily and after careful deliberation.

**Signed this** \_\_\_\_\_ **day of** \_\_\_\_\_, **20**\_\_\_\_\_.  
signature \_\_\_\_\_  
address \_\_\_\_\_  
city \_\_\_\_\_ state \_\_\_\_\_

**F) WITNESSES:** I declare that the person who signed this document, or asked another to sign this document on his or her behalf, did so in my presence, that he or she is personally known to me, and that he or she appears to be of sound mind and free of duress or undue influence. I am 18 years of age or older, and am not designated by this or any other document as the person's health care representative, nor as an alternate health care representative.

- |                        |                        |
|------------------------|------------------------|
| 1. witness _____       | 2. witness _____       |
| address _____          | address _____          |
| city _____ state _____ | city _____ state _____ |
| signature _____        | signature _____        |
| date _____             | date _____             |

**COMBINED ADVANCE DIRECTIVE FOR HEALTH CARE**  
*(Combined Proxy and Instruction Directive)*

I understand that as a competent adult I have the right to make decisions about my health care. There may come a time when I am unable, due to physical or mental incapacity, to make my own health care decisions. In these circumstances, those caring for me will need direction concerning my care and will turn to someone who knows my values and health care wishes. I understand that those responsible for my care will seek to make health care decisions in my best interests, based upon what they know of my wishes. In order to provide the guidance and authority needed to make decisions on my behalf:

I, \_\_\_\_\_ hereby declare and make known my instructions and wishes for my future health care. This advance directive for health care shall take effect in the event I become unable to make my own health care decisions, as determined by the physician who has primary responsibility for my care, and any necessary confirming determinations. I direct that this document become part of my permanent medical records.

**In completing Part One of this directive, you will designate an individual you trust to act as your legally recognized health care representative to make health care decisions for you in the event you are unable to make decisions for yourself.**

**In completing Part Two of this directive, you will provide instructions concerning your health care preferences and wishes to your health care representative and others who will be entrusted with responsibility for your care, such as your physician, family members and friends.**

**Part One: Designation of a Health Care Representative**

**A) CHOOSING A HEALTH CARE REPRESENTATIVE:**

**I hereby designate:**

*name* \_\_\_\_\_

*address* \_\_\_\_\_

*city* \_\_\_\_\_ *state* \_\_\_\_\_

*telephone* \_\_\_\_\_

as my health care representative to make any and all health decisions for me, including decisions to accept or to refuse any treatment, service or procedure used to diagnose or treat my physical or mental condition, and decisions to provide, withhold or withdraw life-sustaining measures. I direct my representative to make decisions on my behalf in accordance with my wishes as stated in this document, or as otherwise known to him or her. In the event my wishes are not clear, or a situation arises I did not anticipate, my health care representative is authorized to make decisions in my best interests, based upon what is known of my wishes.

I have discussed the terms of this designation with my health care representative and he or she has willingly agreed to accept the responsibility for acting on my behalf.

**B) ALTERNATE REPRESENTATIVES:** If the person I have designated above is unable, unwilling or unavailable to act as my health care representative, I hereby designate the following person(s) to act as my health care representative, in order of priority stated:

- |                        |                        |
|------------------------|------------------------|
| 1. name _____          | 2. name _____          |
| address _____          | address _____          |
| city _____ state _____ | city _____ state _____ |
| telephone _____        | telephone _____        |

**Part Two: Instruction Directive**

*In Part Two, you are asked to provide instructions concerning your future health care. This will require making important and perhaps difficult choices. Before completing your directive, you should discuss these matters with your health care representative, doctor, family members or others who may become responsible for your care.*

*In Sections C and D, you may state the circumstances in which various forms of medical treatment, including life-sustaining measures, should be provided, withheld or discontinued. If the options and choices below do not fully express your wishes, you should use Section E, and/or attach a statement to this document which would provide those responsible for your care with additional information you think would help them in making decisions about your medical treatment. **Please familiarize yourself with all sections of Part Two before completing your directive.***

**C) GENERAL INSTRUCTIONS:** To inform those responsible for my care of my specific wishes, I make the following statement of personal views regarding my health care:

**Initial ONE of the following two statements with which you agree:**

- |  |  |
|--|--|
| 1. ____ I direct that all medically appropriate measures be provided to sustain my life, regardless of my physical or mental condition | 2. ____ There are circumstances in which I would not want my life to be prolonged by further medical treatment. In these circumstances, life-sustaining measures should not be initiated and if they have been, they should be discontinued. I recognize that this is likely to hasten my death. In the following, I specify the circumstances in which I would choose to forego life-sustaining measures. |
|--|--|

*If you have initialed statement 2, on the following page please initial each of the statements (a, b, c) with which you agree:*

a. \_\_\_\_\_ I realize that there may come a time when I am diagnosed as having an incurable and irreversible illness, disease, or condition. If this occurs, and my attending physician and at least one additional physician who has personally examined me determine that my condition is **terminal**, I direct that life-sustaining measures which would serve only to artificially prolong my dying be withheld or discontinued. I also direct that I be given all medically appropriate care necessary to make me comfortable and to relieve pain.

**In the space provided, write in the bracketed phrase with which you agree:**

To me, terminal condition means that my physicians have determined that:

---

[I will die within a few days] [I will die within a few weeks]  
[I have a life expectancy of approximately \_\_\_\_\_ or less (enter 6 months, or 1 year)]

b. \_\_\_\_\_ If there should come a time when I become **permanently unconscious**, and it is determined by my attending physician and at least one additional physician with appropriate expertise who has personally examined me, that I have totally and irreversibly lost consciousness and my capacity for interaction with other people and my surroundings, I direct that life-sustaining measures be withheld or discontinued. I understand that I will not experience pain or discomfort in this condition, and I direct that I be given all medically appropriate care necessary to provide for my personal hygiene and dignity.

c. \_\_\_\_\_ I realize that there may come a time when I am diagnosed as having an **incurable and irreversible** illness, disease, or condition which may not be terminal. My condition may cause me to experience severe and progressive physical or mental deterioration and/or a permanent loss of capacities and faculties I value highly. If, in the course of my medical care, the burdens of continued life with treatment become greater than the benefits I experience, I direct that life-sustaining measures be withheld or discontinued. I also direct that I be given all medically appropriate care necessary to make me comfortable and to relieve pain.

*(Paragraph c. covers a wide range of possible situations in which you may have experienced partial or complete loss of certain mental and physical capacities you value highly. If you wish, in the space provided below you may specify in more detail the conditions in which you would choose to forego life-sustaining measures. You might include a description of the faculties or capacities, which, if irretrievably lost would lead you to accept death rather than continue living. You may want to express any special concerns you have about particular medical conditions or treatments, or any other considerations which would provide further guidance to those who may become responsible for your care. If necessary, you may attach a separate statement to this document or use **Section E** to provide additional instructions.)*

Examples of conditions which I find unacceptable are:

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**D) SPECIFIC INSTRUCTIONS: Artificially Provided Fluids and Nutrition; Cardiopulmonary Resuscitation (CPR).** *On page 3 you provided general instructions regarding life-sustaining measures. Here you are asked to give specific instructions regarding two types of life-sustaining measures-artificially provided fluids and nutrition and cardiopulmonary resuscitation.*

**In the space provided, write in the bracketed phrase with which you agree:**

1. In the circumstances I initialed on page 3, I also direct that artificially provided fluids and nutrition, such as by feeding tube or intravenous infusion,

---

**[be withheld or withdrawn and that I be allowed to die]  
[be provided to the extent medically appropriate]**

2. In the circumstances I initialed on page 3, if I should suffer a cardiac arrest, I also direct that cardiopulmonary resuscitation (CPR)

---

**[not be provided and that I be allowed to die]  
[be provided to preserve my life, unless medically inappropriate or futile]**

3. If neither of the above statements adequately expresses your wishes concerning artificially provided fluids and nutrition or CPR, please explain your wishes below.

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**E) ADDITIONAL INSTRUCTIONS:** *(You should provide any additional information about your health care preferences which is important to you and which may help those concerned with your care to implement your wishes. You may wish to direct your health care representative, family members, or your health care providers to consult with others, or you may wish to direct that your care be provided by a particular physician, hospital, nursing home, or at home. If you are or believe you may become pregnant, you may wish to state specific instructions. If you need more space than is provided here you may attach an additional statement to this directive.)*

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**F) BRAIN DEATH:** *(The State of New Jersey recognizes the irreversible cessation of all functions of the entire brain, including the brain stem (also known as whole brain death), as a legal standard for the declaration of death. However, individuals who cannot accept this standard because of their personal religious beliefs may request that it not be applied in determining their death.)*

**Initial the following statement only if it applies to you:**

\_\_\_\_\_ To declare my death on the basis of the whole brain death standard would violate my personal religious beliefs. I therefore wish my death to be declared solely on the basis of the traditional criteria of irreversible cessation of cardiopulmonary (heartbeat and breathing) function.

**G) AFTER DEATH - ANATOMICAL GIFTS:** *(It is now possible to transplant human organs and tissue in order to save and improve the lives of others. Organs, tissues and other body parts are also used for therapy, medical research and education. This section allows you to indicate your desire to make an anatomical gift and if so, to provide instructions for any limitations or special uses.)*

**Initial the statements which express your wishes:**

1. \_\_\_\_\_ **I wish** to make the following anatomical gift to take effect upon my death:

- A. \_\_\_\_\_ any needed organs or body parts
  - B. \_\_\_\_\_ only the following organs or parts
- 

for the purposes of transplantation, therapy, medical research or education, or

- C. \_\_\_\_\_ my body for anatomical study, if needed.
  - D. \_\_\_\_\_ special limitations, if any:
- 

If you wish to provide additional instructions, such as indicating your preference that your organs be given to a specific person or institution, or be used for a specific purpose, please do so in the space provided below.

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2. \_\_\_\_\_ **I do not wish** to make an anatomical gift upon my death.

**Part Three: Signature and Witnesses**

**H) COPIES:** The original or a copy of this document has been given to the following people (*NOTE: If you have chosen to designate a health care representative, it is important that you provide him or her with a copy of your directive.*)

- |                        |                        |
|------------------------|------------------------|
| 1. name _____          | 2. name _____          |
| address _____          | address _____          |
| city _____ state _____ | city _____ state _____ |
| telephone _____        | telephone _____        |

The New Jersey Commission on Legal and Ethical Problems in the Delivery of Health Care

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**I) SIGNATURE:** By writing this advance directive, I inform those who may become entrusted with my health care of my wishes and intend to ease the burdens of decision making which this responsibility may impose. I have discussed the terms of this designation with my health care representative and he or she has willingly agreed to accept the responsibility for acting on my behalf in accordance with this directive. I understand the purpose and effect of this document and sign it knowingly, voluntarily and after careful deliberation.

**Signed this** \_\_\_\_\_ **day of** \_\_\_\_\_, **20**\_\_\_\_\_.  
*signature* \_\_\_\_\_  
*address* \_\_\_\_\_  
*city* \_\_\_\_\_ *state* \_\_\_\_\_

**J) WITNESSES:** I declare that the person who signed this document, or asked another to sign this document on his or her behalf, did so in my presence, that he or she is personally known to me and that he or she appears to be of sound mind and free of duress or undue influence. I am 18 years of age or older, and am not designated by this or any other document as the person's health care representative nor as an alternate health care representative.

1. *witness* \_\_\_\_\_  
*address* \_\_\_\_\_  
*city* \_\_\_\_\_ *state* \_\_\_\_\_  
*signature* \_\_\_\_\_  
*date* \_\_\_\_\_

2. *witness* \_\_\_\_\_  
*address* \_\_\_\_\_  
*city* \_\_\_\_\_ *state* \_\_\_\_\_  
*signature* \_\_\_\_\_  
*date* \_\_\_\_\_

## INSTRUCTION DIRECTIVE

I understand that as a competent adult I have the right to make decisions about my health care. There may come a time when I am unable, due to physical or mental incapacity, to make my own health care decisions. In these circumstances, those caring for me will need direction concerning my care and they will require information about my values and health care wishes. In order to provide the guidance and authority needed to make decisions on my behalf:

A) I, \_\_\_\_\_, hereby declare and make known to my family, physician, and others, my instructions and wishes for my future health care. I direct that all health care decisions, including decisions to accept or refuse any treatment, service or procedure used to diagnose, treat or care for my physical or mental condition and decisions to provide, withhold or withdraw life-sustaining measures, be made in accordance with my wishes as expressed in this document. This instruction directive shall take effect in the event I become unable to make my own health care decisions, as determined by the physician who has primary responsibility for my care, and any necessary confirming determinations. I direct that this document become part of my permanent medical records.

### **Part One: Statement of My Wishes Concerning My Future Health Care**

*In Part One, you are asked to provide instructions concerning your future health care. This will require making important and perhaps difficult choices. Before completing your directive, you should discuss these matters with your doctor, family members or others who may become responsible for your care.*

*In Section B and C, you may state the circumstances in which various forms of medical treatment, including life-sustaining measures, should be provided, withheld or discontinued. If the options and choices below do not fully express your wishes, you should use Section D, and/or attach a statement to this document which would provide those responsible for your care with additional information you think would help them in making decisions about your medical treatment. Please familiarize yourself with all sections of Part One before completing your directive.*

**B) GENERAL INSTRUCTIONS:** To inform those responsible for my care of my specific wishes, I make the following statement of personal views regarding my health care:

**Initial ONE of the following two statements with which you agree:**

1. \_\_\_\_\_ I direct that all medically appropriate measures be provided to sustain my life, regardless of my physical or mental condition

2. \_\_\_\_\_ There are circumstances in which I would not want my life to be prolonged by further medical treatment. In these circumstances, life-sustaining measures should not be initiated and if they have been, they should be discontinued. I recognize that this is likely to hasten my death. In the following, I specify the circumstances in which I would choose to forego life-sustaining measures.

*If you have initialed statement 2 on page 1, please initial each of the statements (a, b, c) with which you agree:*

a. \_\_\_\_\_ I realize that there may come a time when I am diagnosed as having an incurable and irreversible illness, disease, or condition. If this occurs, and my attending physician and at least one additional physician who has personally examined me determine that my condition is **terminal**, I direct that life-sustaining measures which would serve only to artificially prolong my dying be withheld or discontinued. I also direct that I be given all medically appropriate care necessary to make me comfortable and to relieve pain.

**In the space provided, write in the bracketed phrase with which you agree:**

To me, terminal condition means that my physicians have determined that:

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[I will die within a few days] [I will die within a few weeks]  
[I have a life expectancy of approximately \_\_\_\_\_ or less (enter 6 months, or 1 year)]

b. \_\_\_\_\_ If there should come a time when I come **permanently unconscious**, and it is determined by my attending physician and at least one additional physician with appropriate expertise who has personally examined me, that I have totally and irreversibly lost consciousness and my capacity for interaction with other people and my surroundings, I direct that life-sustaining measures be withheld or discontinued. I understand that I will not experience pain or discomfort in this condition, and I direct that I be given all my medically appropriate care necessary to provide for my personal hygiene and dignity.

c. \_\_\_\_\_ I realize that there may come a time when I am diagnosed as having an **incurable and irreversible** illness, disease, or condition which may not be terminal. My condition may cause me to experience severe and progressive physical or mental deterioration and/or a permanent loss of capacities and faculties I value highly. If, in the course of my medical care, the burdens of continued life with treatment become greater than the benefits I experience, I direct that life-sustaining measures be withheld or discontinued. I also direct that I be given all medically appropriate care necessary to make me comfortable and to relieve pain.

*(Paragraph c. covers a wide range of possible situations in which you may have experienced partial or complete loss of certain mental and physical capacities you value highly. If you wish, in the space provided below you may specify in more detail the conditions in which you would choose to forego life-sustaining measures. You might include a description of the faculties or capacities, which, if irretrievably lost would lead you to accept death rather than continue living. You may want to express any special concerns you have about particular medical conditions or treatments, or any other considerations which would provide further guidance to those who may become responsible for your care. If necessary, you may attach a separate statement to this document or use **Section D** to provide additional instructions.)*

Examples of conditions which I find unacceptable are:

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**C) SPECIFIC INSTRUCTIONS: Artificially Provided Fluids and Nutrition; Cardiopulmonary Resuscitation (CPR).** *On page 2 you provided general instructions regarding life-sustaining measures. Here you are asked to give specific instructions regarding two types of life-sustaining measures-artificially provided fluids and nutrition and cardiopulmonary resuscitation.*

**In the space provided, write in the bracketed phrase with which you agree:**

1. In the circumstances I initialed on page 2, I also direct that artificially provided fluids and nutrition, such as by feeding tube or intravenous infusion,

---

**[be withheld or withdrawn and that I be allowed to die]  
[be provided to the extent medically appropriate]**

2. In the circumstances I initialed on page 2, if I should suffer a cardiac arrest, I also direct that cardiopulmonary resuscitation (CPR)

---

**[not be provided and that I be allowed to die]  
[be provided to preserve my life, unless medically inappropriate or futile]**

3. If neither of the above statements adequately expresses your wishes concerning artificially provided fluids and nutrition or CPR, please explain your wishes below.

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**D) ADDITIONAL INSTRUCTIONS:** *(You should provide any additional information about your health care preferences which is important to you and which may help those concerned with your care to implement your wishes. You may wish to direct your family members or your health care providers to consult with others, or you may wish to direct that your care be provided by a particular physician, hospital, nursing home, or at home. If you are or believe you may become pregnant, you may wish to state specific instructions. If you need more space than is provided here you may attach an additional statement to this directive.)*

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**E) BRAIN DEATH:** *(The State of New Jersey recognizes the irreversible cessation of all functions of the entire brain, including the brain stem (also known as whole brain death), as a legal standard for the declaration of death. However, individuals who cannot accept this standard because of their personal religious beliefs may request that it not be applied in determining their death.)*

**Initial the following statement only if it applies to you:**

\_\_\_\_\_ To declare my death on the basis of the whole brain death standard would violate my personal religious beliefs. I therefore wish my death to be declared solely on the basis of the traditional criteria of irreversible cessation of cardiopulmonary (heartbeat and breathing) function.

**F) AFTER DEATH - ANATOMICAL GIFTS:** *(It is now possible to transplant human organs and tissue in order to save and improve the lives of others. Organs, tissues and other body parts are also used for therapy, medical research and education. This section allows you to indicate your desire to make an anatomical gift and if so, to provide instructions for any limitations or special uses.)*

**Initial the statements which express your wishes:**

1. \_\_\_\_\_ **I wish** to make the following anatomical gift to take effect upon my death:

- A. \_\_\_\_\_ any needed organs or body parts
- B. \_\_\_\_\_ only the following organs or parts

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for the purposes of transplantation, therapy, medical research or education, or

- C. \_\_\_\_\_ my body for anatomical study, if needed.
- D. \_\_\_\_\_ special limitations, if any:

---

If you wish to provide additional instructions, such as indicating your preference that your organs be given to a specific person or institution, or be used for a specific purpose, please do so in the space provided below.

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2. \_\_\_\_\_ **I do not wish** to make an anatomical gift upon my death.

**Part Two: Signature and Witnesses**

**G) COPIES:** The original or a copy of this document has been given to the following people (*NOTE: It is important that you provide a family member, friend or your physician with a copy of your directive.*):

- |                        |                        |
|------------------------|------------------------|
| 1. name _____          | 2. name _____          |
| address _____          | address _____          |
| city _____ state _____ | city _____ state _____ |
| telephone _____        | telephone _____        |

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**H) SIGNATURE:** By writing this advance directive, I inform those who may become entrusted with my health care of my wishes and intend to ease the burdens of decision making which this responsibility may impose. I understand the purpose and effect of this document and sign it knowingly, voluntarily and after careful deliberation.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

signature \_\_\_\_\_

address \_\_\_\_\_

city \_\_\_\_\_ state \_\_\_\_\_

**D) WITNESSES:** I declare that the person who signed this document, or asked another to sign this document on his or her behalf, did so in my presence, that he or she is personally known to me and that he or she appears to be of sound mind and free of duress or undue influence. I am 18 years of age or older, and am not designated by this or any other document as the person's health care representative nor as an alternate health care representative.

1. witness \_\_\_\_\_

address \_\_\_\_\_

city \_\_\_\_\_ state \_\_\_\_\_

signature \_\_\_\_\_

date \_\_\_\_\_

2. witness \_\_\_\_\_

address \_\_\_\_\_

city \_\_\_\_\_ state \_\_\_\_\_

signature \_\_\_\_\_

date \_\_\_\_\_



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**Notes:**



# Checklist: Questions to Ask Yourself

## I. Thinking about Your Health Care Wishes?

- A. Why am I writing an advance directive?
- B. What are my treatment wishes?
  - 1. in situations near the end of life?
  - 2. in situations of serious injury or illness?

## II. Talking with Others

- A. Physicians and other health care professionals
  - 1. do I understand the medical terminology?
  - 2. do they understand my wishes?
- B. My friends, family and others
  - 1. have I directly and thoroughly discussed my wishes with them?
  - 2. do they understand my wishes?

## III. Selecting a Health Care Representative

- A. Am I confident that my designated representative understands my personal values and health care wishes?
- B. Does my health care representative understand his or her responsibilities?
- C. Has he or she clearly agreed to serve as my representative and to communicate my wishes to my doctor and other concerned with my care?
- D. Have I selected an alternative health care representative?

## IV. My Instructions. Have I clearly stated my instructions and included other relevant information about my treatment wishes regarding:

- A. the provision, withholding or withdrawal of specific treatments?
- B. artificially provided fluids and nutrition?
- C. the medical conditions in which I want my wishes implemented?
- D. special considerations I may have concerning my care and treatment?

## V. Witnesses. Have I had my directive properly witnessed?

## VI. Distribution of My Advance Directive. Have I given a copy of my directive to those who should have one, such as:

- A. my health care representative?
- B. my physician or other health care provider?
- C. the hospital or nursing home which I am about to enter?
- D. family members, friends, alternate representatives and my religious advisor?

## VII. Periodic Review. Have I made a note to review my directive on a regular basis in the future?

## VIII. Wallet Card. Have I completed the wallet size card located on the inside back cover of this brochure which tells others I have an advance directive and who to contact for further information?

### I HAVE AN ADVANCE DIRECTIVE FOR HEALTH CARE

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

*for information please contact as soon as possible:*

Name: \_\_\_\_\_ tel.# \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_

**OR**

Name: \_\_\_\_\_ tel.# \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

### ORGAN DONOR CARD

In the hope that I may help others, I hereby make this anatomical gift, to take effect upon my death. The words and marks below indicate my desires.

I give: \_\_\_\_\_ Any needed organs or parts

or: \_\_\_\_\_ Only the following organs or parts.

\_\_\_\_\_

For the purposes of transplantation, therapy, medical research or education.

Signed by the Donor and the following two witnesses in the presence of each other.

Signature of donor \_\_\_\_\_ Date of birth \_\_\_\_\_  
of Donor \_\_\_\_\_

Date Signed \_\_\_\_\_ City & State \_\_\_\_\_

Witness \_\_\_\_\_ Witness \_\_\_\_\_

This Is A Legal Document Under the Uniform Anatomical Gift Act.