

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.

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(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 above, 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.

Choose the bracketed phrase with which you agree and write it in the space below:

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 6 months or less]

[I have a life expectancy of approximately 1 year or less]

- 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.

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(Paragraph c on the previous page 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 that 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 that I find unacceptable are:

(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.

(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.

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(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 that 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.

2. ____ I do not wish to make an anatomical gift upon my death.

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Part Two: Signature and Witnesses

(G) Copies:

It is important that you provide a family member, friend or your physician with a copy of your directive.

The original or a copy of this document has been given to the following people:

Name: _____

Name: _____

Address: _____

Address: _____

City / State / Zip: _____

City / State / Zip: _____

Phone: _____

Phone: _____

(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: _____

Print Full Name: _____

Address: _____

City / State / Zip: _____

(I) 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.

Witness Signature: _____

Witness Signature: _____

Print Full Name: _____

Print Full Name: _____

Date: _____

Date: _____

Address: _____

Address: _____

City / State / Zip: _____

City / State / Zip: _____