An affiliate of the Saint Barnabas Health Care System

ADVANCE DIRECTIVE FOR HEALTHCARE
INSTRUCTIONAL AND PROXY DIRECTIVE

To my family and healthcare team:

I, ____,
make this statement as a directive to be followed if for any reason I lose my capacity to make healthcare decisions. I recognize that I retain my right to make my own healthcare decision as long as I have decision-making capacity.

Initial one:

________ I direct that all life-sustaining procedures, including but not limited to CPR and artificially provided fluids and nutrition **be withheld or withdrawn** if I am ever, in the professional opinion of my physician and one other physician:

a. permanently unconscious or
b. terminally, incurably and/or irreversibly ill or
c. have severe physical and/or mental deterioration from which I am not expected to recover.

________ I direct that all life-sustaining procedures **be provided** regardless of my mental and/or physical condition.

In either case, I direct that I be kept comfortable as possible.

Additional instructions: ____

____

Should there be any clarification needed on my above expressed wishes or should an unanticipated situation arise, I direct that healthcare decisions be made for me by (cannot be your physician):

Name: ____ Phone: _________________________

Address: ____

____

If the above named person is unable or unwilling to make healthcare decisions for me, I direct that healthcare decisions for me be made by (cannot be your physician):

Name: ____ Phone: ___________________________

Address: ____

____

Signed: ____ **Date:** __________________

Witnesses (must be 18 years old and cannot be person(s) named to make healthcare decisions)

Name: __________________________ Signed: __________________________ Date: _____________

Name: __________________________ Signed: __________________________ Date: _____________

Why you should complete an Advance Directive for Healthcare:

As a consumer, you have the right and the responsibility to make informed decisions about your health care. You have the right to ask questions about any proposed test or treatment. You have the right to have those questions answered in terms you can understand. You have the right to accept or refuse medical treatment, even life-sustaining treatment. The recommendations and assistance of your physician and family are very important, but the decision is up to you! Often these very personal and emotional situations may involve religious or moral values. If you should ever become unable to speak for yourself due to a physical or mental condition, how would you want these decisions to be made? This document allows you to provide guidance for these decisions and to name a person you trust to help.

Terms you should understand:

1. **HEALTHCARE DECISIONS**- a decision to accept or refuse any treatment, service or procedure used to diagnose, treat, or care for your physical or mental condition including life-sustaining treatment and treatment by any particular healthcare professional or institution.
2. **CAPACITY TO MAKE HEALTHCARE DECISIONS**- the ability to understand the nature of your own medical condition and the benefits, risks and burdens of any proposed course of treatment.
3. **PERMANENTLY UNCONSCIOUS**- total and irreversible loss of consciousness and capacity for interaction with your environment.
4. **TERMINALLY ILL**- the end stage of an irreversibly fatal illness, disease or condition, usually with a life expectancy of less than six months.
5. **LIFE-SUSTAINING TREATMENT**- the use of any medical device or procedure, including artificially provided fluids and nutrition, without which, you would die.
6. **WITHHELD OR WITHDRAWN**- to not start or stop.

How to get assistance in completing this document:

We hope that we have made this document simple to understand and complete. However, should you have any questions about the medical implications for you, please consult your physician. Additionally, Community Medical Center has various persons and programs in place to be of assistance to you. For more information call: The Lighthouse at 1-800-621-0096.

What you should do with this document:

Upon completion of this document, you should make several photocopies. Keep the original in a safe place. Give a copy to and discuss the contents with your physician(s) and the person(s) you have named to make healthcare decisions for you. You will be asked for a copy if you are ever admitted to a home care service, extended care facility or hospital.

Review the document periodically to be sure that it reflects your current wishes. If you want to make a change simply write on the document, initial and date the change and have the change witnessed by two people or have it notarized. Be sure to notify those persons with copies of the change.

Congratulations! You have taken an important step towards taking charge of your health!