Hunterdon Health

Instruction Directive - (Living Will)

NAME DOB

2100 Wescott Drive, Flemington, NJ 08822 * 908-788-6100

To My Family, Doctors, and All Those Concerned with My Care:

I, _____, being of sound mind, make this statement as a directive to be followed if for any reason I become unable to participate in decisions regarding my medical care. (*Initial* any that apply)

A. _____ 1. I direct that life-sustaining procedures be *withheld* or *withdrawn*: a) if I become permanently unconscious; b) if I have a terminal illness; c) if I experience extreme mental deterioration; or d) if I have another type of irreversible illness. The above conditions shall have no reasonable expectation of recovery or chance of regaining a meaningful quality of life. These medical conditions shall be determined by my attending physician and at least one additional physician. I understand that I will be kept comfortable.

OR

_____ 2. I direct that all medically appropriate measures be provided to sustain my life, regardless of my physical or mental condition.

B. This section asks you to think about the values that are important to you regarding treatment in case of severe mental or physical illness.

_____ 1. I do not wish my life to be prolonged by medical treatment(s) if my quality of life is unacceptable to me. The following are conditions that are unacceptable to me. (Initial only those that describe a way of living that you could not tolerate):

_____ a) Permanently unconscious with a ventilator breathing for me.
_____ b) Permanently unconscious with a feeding tube and/or intravenous (IV) hydration.
_____ c) On a ventilator when there is little or no chance of recovery.
_____ d) Being conscious (awake), but unable to communicate (for example, with a stroke), and being fed with a feeding tube and/or hydrated with IV's to keep me alive.
_____ e) Living with a dementia like Alzheimer's disease so severe that I am unable to recognize those who love me.

OR

_____ 2. I want to live as long as possible, regardless of the quality of life that I experience.

C. If you chose A. 1., above, the life sustaining procedures that would be withheld or withdrawn include but are not limited to: CPR, mechanical ventilation, surgery, chemotherapy, radiation, dialysis, transfusion, and antibiotics. Initial the following if it applies to you.

_____ In the circumstances described in A. 1., above, I also direct that artificially provided nutrition and fluids be withheld and withdrawn and that I be allowed to die.

D. _____ Upon my death, I am willing to donate any parts of my body that may be beneficial to others.

Additional Comments or Exceptions:

_____

These directions express my legal right to request or refuse treatment. Therefore, I expect my family, doctor, and all those concerned with my care to regard themselves as legally and morally bound to act in accord with my wishes.

Signed _____ Date _____

Witnesses (cannot be a healthcare representative or alternative representative if any named on the other side of this page).
I declare that the person who signed this document or asked another to sign this document on his/her behalf, did so in my presence and that he/she appears to be of sound mind and free of duress or undue influence.

Witness _____ Date _____

Witness _____ Date _____

Reminder: Give a copy of this document to your doctor, health care representative, and other concerned individuals.

Written and approved by the Medical Society of New Jersey 7/95

Hunterdon Health

Durable Power of Attorney For Health Care (Proxy Directive)

2100 Wescott Drive, Flemington, NJ 08822 * 908-788-6100

NAME DOB

If you wish, you may use this section to designate someone to make treatment decisions if you are unable to do so. Your Living Will declaration will be in effect even if you have not designated a proxy.

I, _____, designate the following person as my health care representative to make any and all health care decisions for me, acting in my best interest, in the event that I become incapable of making decisions for myself.

Name _____ Relationship _____

Street _____

City _____ State _____ Zip Code _____ Telephone _____

If the person I have named above is unable to act as my health care representative, I hereby designate the following person(s) to do so:

1. Name _____ Relationship _____

   Street _____

   City _____ State _____ Zip Code _____ Telephone _____

2. Name _____ Relationship _____

   Street _____

   City _____ State _____ Zip Code _____ Telephone _____

SPECIFIC DIRECTIONS: Please initial the statement below that best expresses your wishes.

_____ My health care representative is authorized to direct that artificially provided fluids and nutrition, such as by feeding tube of IV 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.

Signed _____ Date _____

Witness (cannot be a healthcare representative or alternative representative listed above).
I declare that the person who signed this document or asked another to sign this document on his/her behalf, did so in my presence and that he/she appears to be of sound mind and free of duress or undue influence.

Witness _____ Date _____

Witness _____ Date _____

Reminder: Give a copy of this document to your doctor, health care representative, and other concerned individuals.

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