

# L'CHAIM!

Please accept this advance care planning toolkit  
as a gift to you and your family from  
*Sukkat Shalom*, Jewish Hospice Service,  
of Samaritan Healthcare & Hospice  
in collaboration with our community partners.

## תכּוּס מוּלַשׁ

*Sukkat Shalom – A Shelter of Peace*



Board of Rabbis

# The Gift of *Timely Conversations*

## Resources for Individuals, Families and Congregations

Shalom:

Thank you for your request for these forms, the majority of which have been taken from the previously published "A Time to Prepare". These Life Data forms serve as a basis for a family beginning to have a conversation around end of life and care decisions. We have also included a section on a sample detailed Advanced Directive and Health Care proxy-medical power of attorney and a suggested prayer for when one signs the advanced directive.

This material also includes a sample ethical will form as well as a sample form for a POLST: Physicians/Practitioners Order for Life Sustaining Treatment. ***Please note that you will need to check to see the legal status of the POLST from where you live. This may vary from State to State in USA.***

Finally we did include a brief section on a suggested "Ritual for Saying Goodbye", drawn from our tradition as well as a very meaningful prayer/meditation, created by Rabbi Janet Marder of California, entitled "Prayer for the End of Life".

Please note that the major denominations within our North American community see advanced directives and organ donation as a positive, as well as hospice and comfort care at the end of life. You can search your specific denominational sites for texts that support these positions. We have also included a very brief bibliography section in case you wish to pursue some of these concepts.

Lastly, ***please remember to distribute your advanced directive/health care proxy at all who would need to see it in case of need. Do not lock it away in a safe deposit box. Make sure your clergy, doctors, lawyers and key family members have copies. And, given the pace of medical technology, and your own views, it is a good idea to review your plans and wishes every few years.***

Thank you and shalom.

Richard F. Address, D.Min  
Jewish Sacred Aging

# Blessings Upon Signing Your Directive/Health Care Proxy

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Blessed is the Eternal who has granted us life, sustained us and enabled us to reach this season.

God who has given me the power of choice, and who has brought me the strength to make these decisions today, I thank you for granting me the wisdom to think ahead and to understand the great range of possibilities that could come in the future.

When the time comes that I am no longer able to make decisions on my own behalf, may my wishes be carried out by those who are close to me.

I have been blessed with so much and may my family be at peace with my decisions. May we love one another and cherish our time together.

Tess Levine

Eternal God, in this time that \_\_\_\_\_ has made his/her wishes known, we are reminded that life is in partnership with You. While so much is out of our control, we are grateful that we can make choices in our life, make them known, and have them acted out in the event we no longer have the ability to do so ourselves.

*Baruch Atah Adonai*, who has given us free will and agency in our lives.

Rabbi Dan Fliegel

# The Ethical Will

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*I have singled him out, that he may instruct his children and his household after him to keep the way of Adonai by doing what is just and right, in order that Adonai may bring about for Abraham what Adonai has promised him.*

GENESIS 18:19

These words marked the beginning of the custom of one generation's leaving an ethical will for the next. For centuries parents have left a document for their children through which the bequeathed a spiritual, moral, and ethical legacy. In essence this document is just another way in which we transmit the fundamental values of life's dignity and sanctity and fulfill our responsibility to pass on these values to those we leave behind.

A personal ethical will is a gift that a parent gives his or her child. It is a testimony about living—a prescription based on one's own experience for living a righteous life.

Albert Vorspan, former senior vice president of the Union of American Hebrew Congregations, once described the challenge of leaving behind an ethical will in the following way:

What is the true legacy I can leave my own children?

It is not stocks and bonds and notes and precious stones. It is not even such wisdom as I may have accumulated in my life. For what is man and what is life? I have lived and I will die, but the deepest mysteries of life

# Life Data

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1. Name

Hebrew

2. Legal Residence

3. Telephone Number

4. Birthplace and Date

5. Spouse of Next of Kin

6. Conversion: Date/Place/Under Auspices of

7. Children (Name and Social Security Numbers)

8. Parents

Mother (Maiden Name)

Father

Father's Hebrew Name

9. Grandparents

Maternal

Paternal

10. Grandchildren

11. Social Security Number

12. VA Claim Number

13. Service Serial Number

14. Date and Place of Discharge

15. Length of Residence in Present Location

16. Blood/Genetic Information

17. Citizenship Naturalization Information (if applicable)

## LOCATION OF TANGIBLE PROPERTY

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1. Cash
2. Jewelry
3. Objects of Art
4. Furs (Storage?)
5. Boats, Aircraft, Motor Vehicles, etc.
6. Other
7. Locker  
    Key or combination
8. Briefcase  
    Key or combination
9. Ministorage/Warehouse  
    Key

## LOCATION OF DOCUMENTS

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1. I will

The assets listed in numbers 2-4 are considered outside the jurisdiction of the probate court.

2. Life Insurance Policy (if payable to beneficiary other than the estate)
3. Jointly Owned Property  
  
    Deed to Home  
    Deeds to Other Property
4. Trusts
5. Stocks/Securities Certificates
6. Bonds

7. Real Property of the Deceased Not Held Jointly (must be probated)

8. Other Assets (i.e. royalties, patents, etc.)

9. Other Insurance Policies

Health

Disability

Home

Umbrella

Auto

10. Bankbooks

In certain jurisdiction a survivor may withdraw funds only from an account that has been set up with rights of survivorship.

Savings

Money Market (s)

Checking

CD (s)

11. Record of IRA (s)

12. Debts/Monthly Obligations

Mortgage: \_\_\_\_\_ Home \_\_\_  
Office

Home

Office

Home Improvement Loan

Others

13. Income Tax Papers/1040 Returns

14. Records of Purchase/Sale

15. Business Agreement/Partnership

16. Pension Information

17. Military Discharge/VA Papers

18. Credit Cards and Account Numbers

19. Title to Automobiles and Auto Registrations
20. Marriage Certificate
21. Birth Certificate/Adoption Papers
22. Naturalization Papers
23. Change of Name Papers
24. Previous Marriage Certificates
25. Divorce Papers
26. Birth Certificates of Children
27. Other Important Documents (i.e., Ethical Will





## **The Gift of Timely Conversations: Reflections on National Healthcare Decisions Day**

By Stephen Goldfine, MD  
Chief Medical Officer, Samaritan Healthcare & Hospice

*“It always seems too early,  
until it’s too late.”*

*Has this ever happened to you?* You keep putting something off, thinking you have all the time in the world, only to find yourself stressed out and caught short – of time, energy, and resources to plan.

Sadly, that scenario is all too common when it comes to talking about what no one wants to think about – pain, illness, and mortality.

That’s why so few Americans give themselves and their families the gift of advance care planning. A study published in the January 2014 edition of *The American Journal of Preventive Medicine* found that only 26.3 percent of the 7,900 respondents had an advance directive – defined as the legal documents that enable you to plan for and share your end-of-life wishes in the event that you are unable to communicate.

By avoiding these topics, we can lose control of having our wishes honored if illness or injury suddenly made us unable to speak for ourselves.

That’s why National Healthcare Decisions Day (NHDD) was created to educate, and empower the public about the importance of advance care planning. NHDD chose the quote above as its 2016 theme to provoke earlier dialogue.

Supporting family conversations – preferably now around the kitchen table, rather than later in the ICU during a crisis – is why I promote National Healthcare Decisions Day.

As a palliative physician, I have these sensitive conversations with patients and families every day. And my conversations always begin at the same place: *How do you define quality of life? What personal and cultural values make life worth living*

*for you? What are your goals for the care you choose to receive—or not receive?*

When I listen and learn what matters most, only then can I work with you on a care plan and choices that are reasonable *for you*. Only then, can I hope to honor your wishes, and help you to achieve physical, emotional, and spiritual comfort for each stage of the journey.

Effective January 1, Medicare underscored the importance of advance care planning talks by approving counseling by primary care physicians in its 2016 physician fee schedule.

But these topics are tough to bring up with those we love. It’s hard to find “the right time.” Let’s use NHDD as a reason to start the conversation.

I’m proud to say that Samaritan has taken on this challenge year-round. Our *Timely Conversations* project has coined the easy-to-remember slogan, “Think. Talk. Act.” These three simple words challenge you to *think* about what matters most to you, *talk* about it with those you love and your healthcare providers, and *act* on those wishes by writing them down and providing copies to all who need them.

Dr. Ira Byock, a leading palliative care expert, has written, “I have an advance directive, not because I have a serious illness, but because I have a family.” So, before it’s too late, celebrate National Healthcare Decisions Day by sharing the gift of timely conversations with your family. It will provide peace of mind, and better healthcare outcomes for years to come.

For conversation tools and resources: [www.Samaritannj.org](http://www.Samaritannj.org)

# The Gift of *Timely Conversations*

## Resources & Conversation Starters

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### Websites

- The Conversation Project – [www.conversationproject.org](http://www.conversationproject.org)
- Conversations of a Lifetime – [www.conversationsofalifetime.org](http://www.conversationsofalifetime.org)
- NJ Department of Health -- <http://www.nj.gov/health/advancedirective/ad/>
- National Institute of Health – Senior Health – [www.nihseniorhealth.gov/endoflife/preparingfortheendoflife/01.html](http://www.nihseniorhealth.gov/endoflife/preparingfortheendoflife/01.html)
- Go Wish – [www.gowish.org](http://www.gowish.org)
- Deathwise – [www.deathwise.org](http://www.deathwise.org)
- POLST – [www.njha.com/polst](http://www.njha.com/polst)
- Caring Info by NHPCO – [www.caringinfo.org](http://www.caringinfo.org)
- Prepare for Your Care - [www.prepareforyourcare.org](http://www.prepareforyourcare.org)
- Dying Matters Let's Talk About It – [www.dyingmatters.org](http://www.dyingmatters.org)
- Ask a Mortician (Youtube channel) – [www.youtube.com/user/orderofthegooddeath](http://www.youtube.com/user/orderofthegooddeath)

### Books

- *Being Mortal: Medicine and What Matters in the End* by Atul Gawande
- *Dying Well: Peace and Possibilities at the End of Life* by Ira Byock
- *The Best Care Possible: A Physicians Quest to Transform Care through the End of Life* by Ira Byock
- *The Four Things that Matter Most* by Ira Byock
- *The Conversation: A Revolutionary Plan for End-of-Life Care* by Angelo E. Volandes, MD
- *The Opposite of Loneliness: Essays and Stories* by Marina Keegan
- *Peace Is Every Step: The Path of Mindfulness in Everyday Life*, by Thich Nhat Hanh
- *The Last Lecture* by Randy Pausch with Jeffrey Zaslow
- *Hope for a Cool Pillow* by Margaret Overton
- *Final Gifts: Understanding the Special Awareness, Needs, and Communication of the Dying* by Maggie Callanan
- *Final Journeys: A Practical Guide for Bringing Care and Comfort at End of Life* by Maggie Callanan

### Conversation Starters

- How would you like to be remembered in 8 words or less?
- What's one story you would want told at your funeral? Who would tell it?
- What are the top three items on your bucket list?
- What is your first experience with loss?
- What scares you most when thinking about end of life?
- Do you know what an advanced directive is? Living will? Five Wishes? What scares you most in thinking about end-of-life? What comforts you most?
- When you think about the last phase of your life, what's most important to you? Ideally how would you like this phase to be? What would it mean to live well for however much time you have left?
- If you became unable to speak for yourself tomorrow, what "unfinished business" would you regret not having resolved – legal, financial, relationships, etc.

# The Gift of *Timely Conversations*

## Glossary of Helpful Terms

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### A

*Adjuvant therapy* - A treatment used with a medication to aid its effect.

*Advance directive* - Written or verbal instructions for your care if you are unable to make decisions.

### C

*Cardiopulmonary resuscitation (CPR)* - A procedure used when a patient's heart stops beating; it can involve compressions of the chest or electrical stimulation.

*Consulting physician* - A doctor with special training or experience who is called in to assist the primary attending physician in matters that need more specialized care.

*Coordination of care* - An approach in which all members of the medical team work together to plan for a patient's care in the hospital and for discharge.

### D

*Do not resuscitate (DNR) order* - A physician's order not to attempt CPR if a patient's heart or breathing stops. The order is written at the request of the patient or family, but it must be signed by a physician to be valid. There are separate versions for home and hospital.

*Durable power of attorney for healthcare* - A document that designates the person you trust to make medical decisions on your behalf if you are unable.

### H

*Healthcare proxy* - Similar to a durable power of attorney for healthcare: a document that designates the person you trust to make medical decisions on your behalf if you are unable.

*Home care* - Services provided in the home, such as nursing and physical therapy.

*Hospice* - Considered a model of quality care, hospice focuses on relieving symptoms and supporting patients with a life expectancy of months, not years. Hospice involves a team-oriented approach to expert medical care, pain management and emotional and spiritual support. The emphasis is on caring, not curing. In most cases hospice care is provided to a patient in his or her own home. It also can be provided in freestanding hospice facilities, hospitals, nursing homes and other long-term care facilities.

*Hydration* - The process of providing water or fluid by mouth, tube, or intravenously.

## I

*Intubation* - The process of inserting a tube into a patient's lungs to help with breathing.

## L

*Life-prolonging treatment* - Medical treatments that aim to cure or remedy an illness.

*Living will* - A document stating a patient's wishes regarding medical treatments.

*Long-term care* - Care that supports patients with chronic impairment for an indefinite period of time; it is provided in nursing facilities, at home or in the community.

## N

*Nonsteroidal anti-inflammatory drugs (NSAIDs)* - A class of pain medications such as ibuprofen and aspirin.

## O

*Opioids* - A class of pain medications that have some opiate narcotic properties but are not derived from opium.

## P

*Palliate* - To relieve the symptoms of a disease or disorder.

*Palliative care* - The medical specialty focused on relief of the pain, symptoms and stress of serious illness. The goal is to improve quality of life. Palliative care is appropriate at any point in an illness and can be provided at the same time as curative treatment.

*Primary attending physician* - A patient's main doctor, who coordinates all referrals to specialists.

## R

*Resuscitation* - Similar to CPR, a protocol used when a patient's heart stops beating; it can involve compressions of the chest or electrical stimulation.

## S

*Subacute care* - Short-term care in a nursing facility, usually for physical therapy.

*Symptom* - A feeling a patient has that indicates a disorder or disease.


## V

*Ventilator* - A machine that breathes for a patient when he or she is unable to do so independently.

# NEW JERSEY PRACTITIONER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)

Follow these orders, then contact physician/APN. This Medical Order Sheet is based on the current medical condition of the person referenced below and their wishes stated verbally or in a written advance directive. Any section not completed implies full treatment for that section. Everyone will be treated with dignity and respect.

Person Name (last, first, middle) \_\_\_\_\_ Date of Birth \_\_\_\_\_

<b>A</b>	<b>GOALS OF CARE</b> <i>(See reverse for instructions. This section does not constitute a medical order.)</i>	
<b>B</b>	<b>MEDICAL INTERVENTIONS:</b> <i>Person is breathing and/or has a pulse</i> <input type="checkbox"/> <b>Full Treatment.</b> Use all appropriate medical and surgical interventions as indicated to support life. If in a nursing facility, transfer to hospital if indicated. See section D for resuscitation status. <input type="checkbox"/> <b>Limited Treatment.</b> Use appropriate medical treatment such as antibiotics and IV fluids as indicated. May use non-invasive positive airway pressure. Generally avoid intensive care. <input type="checkbox"/> Transfer to hospital for medical interventions. <input type="checkbox"/> Transfer to hospital only if comfort needs cannot be met in current location. <input type="checkbox"/> <b>Symptom Treatment Only.</b> Use aggressive comfort treatment to relieve pain and suffering by using any medication by any route, positioning, wound care and other measures. Use oxygen, suctioning and manual treatment of airway obstruction as needed for comfort. Use Antibiotics only to promote comfort. Transfer only if comfort needs cannot be met in current location. Additional Orders: _____	
<b>C</b>	<b>ARTIFICIALLY ADMINISTERED FLUIDS AND NUTRITION:</b> <i>Always offer food/fluids by mouth if feasible and desired.</i> <input type="checkbox"/> No artificial nutrition. <span style="float: right;"> <input type="checkbox"/> Defined trial period of artificial nutrition.  <input type="checkbox"/> Long-term artificial nutrition.                 </span>	
<b>D</b>	<b>CARDIOPULMONARY RESUSCITATION (CPR)</b> <i>Person has no pulse and/or is not breathing</i> <input type="checkbox"/> Attempt resuscitation/CPR <input type="checkbox"/> Do not attempt resuscitation/DNAR Allow <u>N</u> natural <u>D</u> death	
		<b>AIRWAY MANAGEMENT</b> <i>Person is in respiratory distress with a pulse</i> <input type="checkbox"/> Intubate/use artificial ventilation as needed <input type="checkbox"/> Do not intubate - Use O <sub>2</sub> , manual treatment to relieve airway obstruction, medications for comfort.
<b>E</b>	If I lose my decision-making capacity, I authorize my surrogate decision maker noted below to modify or revoke these NJ POLST orders in consultation with my treating physician/APN: Health care representative identified in an advance directive <input type="checkbox"/> Yes <input type="checkbox"/> No Other surrogate decision maker <input type="checkbox"/> Yes <input type="checkbox"/> No	
	_____ Print Name of Surrogate <i>(address on reverse)</i>	_____ Phone Number
<b>F</b>	<b>SIGNATURES:</b> <i>I have discussed this information with my physician/APN.</i> Signature _____ <input type="checkbox"/> Person Named Above <input type="checkbox"/> Health Care Representative/Legal Guardian <input type="checkbox"/> Spouse/Civil Union Partner <input type="checkbox"/> Parent of Minor <input type="checkbox"/> Other Surrogate _____	Has the person named above made an anatomical gift: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <i>These orders are consistent with the person's medical condition, known preferences and best known information.</i> _____ PRINT - Physician/APN Name <span style="float: right;">Phone Number</span> _____ Physician/APN Signature (Mandatory) <span style="float: right;">Date/Time</span> _____ Professional License Number

# HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTHCARE PROFESSIONALS AS NECESSARY

PRINT PERSON'S NAME (LAST, FIRST, MIDDLE)

DATE OF BIRTH

PRINT PERSON'S ADDRESS

## CONTACT INFORMATION

PRINT SURROGATE HEALTH CARE DECISION MAKER

ADDRESS

PHONE NUMBER

## DIRECTIONS FOR HEALTH CARE PROFESSIONAL

### COMPLETING POLST

- Must be completed by a physician or advance practice nurse.
- Use of original form is strongly encouraged. Photocopies and faxes of signed POLST forms may be used.
- Any incomplete section of POLST implies full treatment for that section.

### REVIEWING POLST

POLST orders are actual orders that transfer with the person and are valid in all settings in New Jersey. It is recommended that POLST be reviewed periodically, especially when:

- The person is transferred from one care setting or care level to another, or
- There is a substantial change in the person's health status, or
- The person's treatment preferences change.

### MODIFYING AND VOIDING POLST - *An individual with decision making capacity can always modify/void a POLST at any time.*

- A surrogate, if designated in Section E on the front of this form, may, at any time, void the POLST form, change his/her mind about the treatment preferences or execute a new POLST document based upon the person's known wishes or other documentation such as an advance directive.
- A surrogate decision maker may request to modify the orders based on the known desires of the person or, if unknown, the person's best interest.
- To void POLST, draw a line through all sections and write "VOID" in large letters. Sign and date this line.

### SECTION A

What are the specific goals that we are trying to achieve by this treatment plan of care? This can be determined by asking the simple question: "What are your hopes for the future?" Examples include but not restricted to:

- Longevity, cure, remission
- Better quality of life
- Live long enough to attend a family event (wedding, birthday, graduation)
- Live without pain, nausea, shortness of breath
- Eating, driving, gardening, enjoying grandchildren

*Medical providers are encouraged to share information regarding prognosis in order for the person to set realistic goals.*

### SECTION B

- When "limited treatment" is selected, also indicate if the person prefers or does not prefer to be transferred to a hospital for additional care.
- IV medication to enhance comfort may be appropriate for a person who has chosen "symptom treatment only."
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), or bi-level positive airway pressure (BiPAP).
- Comfort measures will always be provided.

### SECTION C

Oral fluids and nutrition should always be offered if medically feasible and if they meet the goals of care determined by the person or surrogate. The administration of nutrition and hydration whether orally or by invasive means shall be within the context of the person's wishes, religion and cultural beliefs.

### SECTION D

Make a selection for the person's preferences regarding CPR and a separate selection regarding airway management.

### SECTION E

This section is applicable in situations where the person has decision making capacity when the POLST form is completed. A surrogate may **ONLY** void or modify an existing POLST form, or execute a new one, if named in this section by the person.

### SECTION F

POLST must be signed by a practitioner, meaning a physician or APN, to be valid. Verbal orders are acceptable with follow-up signature by physician/APN in accordance with facility/community policy. POLST orders should be signed by the person/surrogate. Indicate on the signature line if the person/surrogate is unable to sign, declined to sign, or a verbal consent is given.

**SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED**

**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 _____             |



## 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,

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**[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)

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**[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:

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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 \_\_\_\_\_