Advance Directives in New Jersey

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 that provide information about your treatment preferences to those caring for you, helping to ensure that your wishes are respected.

By using documents known as **advance directives for health care**, you can 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 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
- Appoint a person to make decisions ***and*** provide them with instructions.

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."

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 to have a say in your future medical care 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 to help you choose the kind of directive that best suits your circumstances. A clearly written directive helps prevent disagreements among those close to you and alleviates some of the burdens of decision making that are often experienced by family members, friends and health care providers.

For more information on Advance Directives, contact:

New Jersey Department of Health and Senior Services
Office of the Commissioner
P.O. Box 360, John Fitch Plaza
Trenton, NJ 08625-0360
609-292-7837
Or
Division of Senior Affairs
609-292-3766

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 decisions. 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 interests, 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 _____ Address _____

   City_____ State _____ Zip _____ Telephone _____

2. Name _____ Address _____

   City_____ State _____ Zip _____ Telephone _____

C) SPECIFIC DIRECTION: Please initial the statement below that best expresses your wishes.

1. _____ 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.

2. _____ 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.

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

_____

_____

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

Name _____ Name _____

Address_____ Address_____

City_____ State _____ Zip _____ City_____ State _____ Zip _____

Telephone_____ Telephone_____

E) SIGNATURE: By writing this durable power of attorney for health care, I inform those who may become entrusted with my 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 _____ Zip _____

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, or as an alternate health care representative.

1. Witness _____ 2. Witness _____

Address _____ Address _____

City _____ State ____ Zip _____ City _____ State ____ Zip _____

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 and they will turn to someone who knows 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 **Sections 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 that 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, 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 that 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 my attending physician and at least one additional physician with appropriate expertise who has personally examined me determine 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 that 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 that, 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 4, 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 4, 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 4, 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.

_____

_____

_____

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 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 to 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 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.

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 _____ Address _____

   City_____ State _____ Zip _____ Telephone _____

2. Name _____ Address _____

   City_____ State _____ Zip _____ Telephone _____

H) SIGNATURE: By writing this instruction 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 _____ 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, or as an alternate health care representative.

1. Witness _____
   Address _____
   City _____ State ____ Zip _____
   Signature _____
   Date _____

2. Witness _____
   Address _____
   City _____ State ____ Zip _____
   Signature _____
   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** _____ **Zip** _____

Telephone _____

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, 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 the order of priority stated:

Name _____
Address _____
City _____ State _____ Zip _____
Telephone _____

Name _____
Address _____
City _____ State _____ Zip _____
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 that 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, 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 my attending physician and at least one additional physician with appropriate expertise who has personally examined me determine 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 that 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, that, 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 E** to provide additional instructions.)*

Examples of conditions that I find unacceptable are:

_____

_____

_____

D) SPECIFIC INSTRUCTIONS: Artificially Provided Fluids and Nutrition; Cardiopulmonary Resuscitation (CPR).

On page 10, 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 10, 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 10, 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.

_____

_____

_____

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.

_____

_____

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 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.

Part Three: Signature and Witnesses

H) 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 _____ Address _____

   City_____ State _____ Zip _____ Telephone _____

2. Name _____ Address _____

   City_____ State _____ Zip _____ Telephone _____

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 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 _____ Zip _____

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, or as an alternate health care representative.

1. Witness _____
   Address _____
   City _____ State ____ Zip _____
   Signature _____
   Date_____

2. Witness _____
   Address _____
   City _____ State ____ Zip _____
   Signature _____
   Date_____