ADVANCE DIRECTIVES

Advance directives or "living wills" are recognized in the State of New Jersey as legal documents which offer evidence of an individual's medical treatment preferences. The United States Supreme Court affirmed, in it's Cruzan decision, that an individual's personal wishes are entitled to constitutional protection.

As a competent adult you have the right to make decisions about your health care. However, should you become severely incapacitated, either physically or mentally, you might be unable to make health care decisions for yourself. In such an event, those responsible for your care would try to make decisions based upon what they know of your wishes. An advance directive or living will is designed to provide guidance in such circumstances. An advance directive may help doctors and other caregivers to provide the desired and most appropriate level of care for you.

In **Section C** you may include or exclude specific life-sustaining procedures. You should consult with your physician if you have questions about these procedures. Select either (1) or (2) but not both.

In **Section D** you may specify in more detail the conditions in which you choose to forgo life-sustaining measures. This can be a statement of your values and the quality of life that is acceptable to you. You may want to include your wishes regarding artificially administered fluids and nutrition. You may wish to indicate your preferences regarding at home or hospital care at the end of life or you might wish to give more specific instructions regarding pregnancy. If you need more space than is provided, you can attach an additional statement to the directive.

In **Section E** you have the opportunity to designate a health care representative to help make decisions for you in the event you are incapacitated. This individual should make decisions in accordance with your wishes. If your wishes are not clear, or a situation arises that was not anticipated, the health care representative is expected to make decisions in your best interest based on what is known of your wishes. Whenever possible, you should discuss these matters in advance with the designated health care representative. You do not need an attorney or a physician to complete an advance directive, although you may wish to consult with one. Have your directive witnessed by two adults. If you designate a health care representative he or she can not be a witness. You do not need to have it notarized. After completing the form, share it with family members, your doctors, friends and other persons who should know your health care preferences. Review your advance directive periodically to make sure it still expresses your intent, then initial and date your review.

ADVANCE DIRECTIVE FOR HEALTH CARE
(LIVING WILL)

This Advance Directive has been developed by the Biomedical Ethics Committee of Princeton HealthCare System. It is one of many forms of advance directives which are available; others are equally valid. Completion of an advance directive is voluntary. Your medical care is not contingent upon your completion of an advance directive. Please consider whatever advance directive you may choose carefully. It is important that each person completing an advance directive be fully informed as to its meaning and implications.

To my Family, Doctors and others concerned with my care:

A. 1 _____ , being of sound mind, hereby declare and make known my instructions and wishes for future health care in the event that for reasons due to physical or mental incapacity, I am unable to participate in decisions regarding my care.

B. I understand that I be given appropriate medical care to alleviate pain and keep me comfortable.

C. Please initial the statement or statements with which you agree: (select #1 or #2, not both)

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

2. If I experience extreme mental or physical deterioration such that there is no reasonable expectation of recovery or regaining a meaningful quality of life, then life-prolonging measures should not be initiated; or if they have been, they should be discontinued. Those life-sustaining procedures or treatments that may be withheld or withdrawn include but are not limited to cardiac resuscitation, respiratory support (ventilator) and artificially administered fluids and nutrition.

D. Additional Comments or Instructions

_____

_____

_____

E. Designation of a Health Care Representative

I hereby designate:

Name _____Relationship _____

Street_____

City _____ State _____Telephone_____

as my Health Care Representative to make decisions about accepting, refusing or withdrawing treatment in accordance with my wishes as stated in this document. In the event my wishes are not clear, or a situation arises that 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.

F. Alternative Representative If the person I have designated 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 _____ Telephone _____

2. Name _____Relationship _____

   Street _____

   City _____State _____ Telephone _____

G. I have discussed my wishes with these persons and trust their judgment on my behalf. I understand the purpose and effect of this document, and I sign it knowingly, voluntarily and after careful deliberation.

Signature_____ Date _____

H. Witnesses (cannot be Health Care Representative or Alternative Representative listed in D or E)

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 undue influence.

Witness _____ Date _____

Witness _____Date_____

OR

Notary Certificate

State of _____

County of_____ , **ss**

Subscribed and sworn before me on _____, 20 __ by _____
Affiant's Name

_____ _____ _____
Notary Signature Commission Expiration Date