ADVANCE DIRECTIVE FORM

Advance directives, such as living wills, are recognized in the State of New Jersey as legal documents that offer evidence of an individual's medical treatment preferences. The United States Supreme Court affirmed it is 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 may be unable to make health care decisions for yourself. In such an event, those responsible for your care would try to make decisions based on 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 provide the desired and most appropriate level of care for you.

Instructions for Completing this Advance Directive

In **Section A**, please print your name.

In **Section B**, you may include or exclude specific life-sustaining procedures. You should consult your physician if you have questions about these procedures. Select either (1) or (2), but not both. Option (3) can be selected with either choice.

In **Section C**, you may specify in more detail the conditions in which you chose to forego life-sustaining measures. This can be a statement of your values and the quality of life that is acceptance to you. You may want to include your wishes regarding artificially administered fluids and nutrition; at-home or hospital care at the end of life; or specific instructions regarding pregnancy. If you need more space, you can attach an additional statement to the directive.

In **Section D**, you may indicate your wishes regarding organ and/or tissue donation.

In **Section E**, you have the opportunity to designate a health care representative or proxy to help make decisions for you in the event you are incapacitated. This individual should make decisions for you in accordance with your wishes. If your wishes are not clear, or a situation arises that was not anticipate on what is known about your wishes. Whenever possible, you should discuss these matters in advance with the designated health care representative.

In **Section G**, you must sign your advance directive in the presence of two adult witnesses. You do not need an attorney or a physician to complete an advance directive, although you may wish to consult with one. You may use a notary public to witness your signature, if this is convenient. After completing the form, share it with family members, doctors, friends and other people who should know your health care preferences. Review your advance directive periodically to make sure it still expresses your intent, and then initial and date your review.

This advance directive is one of many forms of advance directives that are available; other forms are equally valid. Completion of an advance directive is voluntary. You do not need to complete the advance directive to receive medical care. Please consider carefully whatever advance directive you may choose. It is important that each person completing an advance directive be fully informed about its meaning and implications.

Robert Wood Johnson University Hospital Somerset | RWJBarnabas HEALTH

Place patient ID sticker here.

ADVANCE DIRECTIVE FOR HEALTH CARE

To my family, doctors and others concerned with my care:

A. I, ____________________________, being of sound mind, hereby declare and make known by 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. Please initial the statement or statements with which you agree. (Select either #1 or #2, but not both.)

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

OR

2. ☐ If I experience extreme mental or physical deterioration such that there is no reasonable expectation of recovery or regaining of 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); artificially administered fluids and nutrition; and dialysis.

3. ☐ I direct that I be given appropriate medical care to alleviate pain and keep me comfortable.

C. Additional comments or instructions: ____________________________

D. After death, it may be possible to transplant human organs or tissues in order to save or improve the lives of others. I wish to be an organ donor: ☐ Yes ☐ No I wish to be a tissue donor: ☐ Yes ☐ No
Comments: ____________________________

E. Designation of a health care representative. I hereby designate:

Name	**Relationship**	**Telephone**	
Street	**City**	**State**	**Zip**

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 on 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.

First Alternate Name	**Relationship**	**Telephone**	
Street	**City**	**State**	**Zip**
Second Alternate Name	**Relationship**	**Telephone**	
Street	**City**	**State**	**Zip**

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

Signature	**Date**	**Time**

List witnesses (cannot be health care representative or alternative representative listed in E or F and must be at least 18 years of age.) I declare that the person who signed this document did so in my presence, and that he or she appears to be of sound mind and free of undue influence.

Witness	**Date**	**Time**
Witness	**Date**	**Time**