

PowerForm Signer Information

Please enter your name and email to begin the signing process.

Your Role:

Originator

Your Name:

Your Email:

Please provide information for any other signers needed for this document.

Role:

Witness 1

Name:

Email:

Role:

Witness 2

Name:

Email:

Role:

Physician

Name:

Email:

[Begin Signing](#)

If there are other roles required for this document to be completed, please enter the name and email of those other recipients. An email will be sent inviting them to sign along with you.

This form is from [Advance Directives for Health Care: Planning Ahead for Important Health Care Decisions](#).

**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, EXAMPLE 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 _____

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 order of priority stated:

1. name EXAMPLE 2. name _____

address _____ address _____

city _____ state _____ city _____ state _____

telephone _____ 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 and 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 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 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 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 the following page 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 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 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 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 or 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 E** to provide additional instructions.)*

Examples of conditions which I find unacceptable are:

D) Specific Instructions: Artificially Provided Fluids and Nutrition; Cardiopulmonary Resuscitation (CPR). *On page 3 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 3, I also direct that artificially provided fluids and nutrition, such as 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 3, 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 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

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: *If you have chosen to designate a health care representative, it is important that you provide him or her with a copy of your directive*):

1. name _____ EXAMPLE _____ 2. name _____

address _____ address _____

city _____ state _____ city _____ state _____

telephone _____ 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 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 this directive. I understand the purpose and effect of this document and sign it knowingly, voluntarily and after careful deliberation.

Signed this _____ **day of** _____, **20**_____.

signature _____ EXAMPLE

address _____

city _____ state _____

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.

1. witness _____

address _____

city _____ state _____

signature _____

date _____

2. witness _____

address _____

city _____ state _____

signature _____

date _____

**New Jersey Commission on Legal and Ethical
Problems in the Delivery of Health Care
(The New Jersey Bioethics Commission)
March 1991**

This form is from [Advance Directives for Health Care: Planning Ahead for Important Health Care Decisions.](#)



A letter to my loved ones...

Dear Loved Ones,

I want the best quality of life possible during my last days.
Therefore, I hereby request as follows...

(a) I ask that medical treatment to alleviate pain, to provide comfort, and to mitigate suffering be provided so that I may be as free of pain and suffering as possible. Please consult with my doctor in this regard.

(b) If my temperature is above normal, I want a cool moist cloth put on my head.

(c) I want my mouth and lips kept moist.

(d) I need to be kept fresh and clean at all times. I wish to have warm baths often or warm showers, if I am stable enough for a shower.

(e) I desire to be massaged with or without warm oils as often as you think will help maintain my skin integrity and provide for my comfort.

(f) I want my personal care such as nail clipping, hair combing, teeth brushing and shaving as long as they do not cause me pain.

I hope my family and friends would consider that...

(a) I enjoy your company and want you with me when possible. I desire that one of you stay with me when it seems that my death may be imminent.

(b) Please continue to talk to me about daily happenings and events, even if you think I don't understand, because I might be able to understand.

(c) Please don't be afraid to hold my hand or hug me.

(d) Please tell the members of my church or synagogue I am sick and ask them to pray for me and visit me.

(e) Please maintain a cheerful atmosphere around me.

(f) Please place pictures of my loved ones in my room, near my bed, or near the place I sit during the day.

(g) My clothes and bed linens are to be kept clean, and they are to be changed as soon as possible, if they have been soiled.

(h) If at all possible, allow me to die in my home.

(i) Please arrange for me to watch television or listen to my favorite sports events.

(j) Let me enjoy the outdoors as often as possible by letting me spend time in my yard, garden and other appropriate outdoor places, even if it causes slight discomfort to either you or me.

(k) I want to have my favorite types of music played when possible.

(l) I want to have religious readings read to me when I am near death.

(m) I want to have my favorite poems read to me from time to time.

I want you to know the following about my thoughts and concerns, if I am disabled and cannot convey these thoughts to you verbally...

(1) I want you to know that I love you.

(2) I would like to be forgiven for the times I have hurt you.

(3) I forgive you for what you may have done to me in my life.

(4) I want you to know that I do not fear death itself.

(5) I want all of my family members to recommit their love for one another.

(6) Please remember me the way I was before I had a terminal illness.

(7) Please help me maintain meaning to my life during this process of dying by realizing that this is an opportunity for personal growth for all.

(8) Don't be afraid to seek counseling, if you have trouble with my death.

If friends want to know how I want to be remembered, tell them the following...

The following person(s) know my funeral plans...

At any memorial service for me, I want to include the following music, songs, readings or other plans for such a service...

I also have the following requests...

In Process

These are requests of my family members, loved ones, and friends, and are not to be considered legal directives to my attorney-in-fact for health care, if any.

(If you wish to change your answer, you may do so by drawing an "X" through the answer you do not want, and circling the answer you prefer.)

Dated this ____ day of _____, 20 ____.

Signature EXAMPLE

Print Name _____

4 of 4 Principal _____

Additional Pages:

In Process

Additional Pages:

In Process