COMBINED ADVANCE DIRECTIVE FOR HEALTH CARE
(Combined Proxy and Instruction Directive)

I understand 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 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.

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 or withhold or withdraw life-sustaining measures. I designate my named health care representative to be my personal representative to receive my medical records and protected health information in compliance with federal Health Insurance Portability and Accountability Act of 1996 (HIPPA) laws and regulations. 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:* _____
   Address: _____
   City: _____*State:* ____
   Telephone: _____

2. *Name:* _____
   Address: _____
   City: _____*State:* ____
   Telephone: _____

C) GENERAL INSTRUCTIONS: To inform those responsible for my care of my specific wishes, I make the following statement of personal views regarding 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 and 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 as 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, my condition is terminal when I have a life expectancy of

_____ (days) (weeks) (months).

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 the 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.

Examples of conditions which I find unacceptable are:

_____

_____

D) SPECIFIC INSTRUCTIONS: Artificially Provided Fluids and Nutrition: Cardiopulmonary Resuscitation (CPR) You had previously provided general instructions regarding life-sustaining measures. Here you are asked to give specific instructions regarding two types of life-sustaining measures – artificially provides fluids and nutrition, and cardiopulmonary resuscitation.

1. In the previous circumstances I initialed, 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 previous circumstances I initialed, 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.

E) ADDITIONAL INSTRUCTIONS: *(You should provide an additional information about your health care preferences which is important to you and which may help those concerned with your health care implement your wishes. You may wish to direct your health care representative, family members, or your health care providers to consult with other, 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 declaration of death. However, individuals who cannot accept this standard because of their personal religious beliefs may request that it may 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 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.

H) SIGNATURE: By writing this advanced directive, I inform those who may become entrusted with my health care of my wishes and intend to ease the burden 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 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 _____

Address _____

City _____ *State* _____

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 representative, nor as an alternate health care representative.

1. Witness _____

Address_____

City _____ State _____

Signature_____

Date_____

2. Witness _____

Address_____

City _____ State _____

Signature_____

Date_____

OR

Sworn and Subscribed to before me this
____ day of _____, 20____

_____
Name:

Title: _____