SHORE | MEDICAL CENTER

Somers Point, NJ 08244

ADVANCE DIRECTIVES (LIVING WILLS)

Advance directives or “living wills” are recognized by New Jersey law as legal documents which indicate an individual’s medical treatment preference.

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 B** you may include or exclude any specific life-sustaining procedures or treatments. You should consult with your physician if you have questions. Select either (1) or (2) but not both. In statement (1) you may specify in more detail the conditions in which you choose to withhold life-sustaining measures. This can be a statement of your values and the quality of life that is acceptable to you.

In **Section C** 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 make decisions in your best interests based on what is known of your wishes. It is important that you 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.

In **Section D** you may have your directive witnessed by two adults or you may have it notarized. If you designate a health care representative he or she can not be a witness. 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.

SUGGESTED TOPICS TO DISCUSS WITH YOUR HEALTH CARE REPRESENTATIVE/PHYSICIAN

Before designating a health care representative, you should discuss your beliefs and wishes with him/her and your physician. To stimulate discussion and clear understanding, we suggest you consider the following questions.

1. Do you think you would want to have any of the following medical treatments performed on you (1) as temporary treatments (2) as life prolonging measures – with no reasonable expectation of recovery:

   A. Cardiopulmonary resuscitation (CPR) – an emergency, temporary measure used if the heart stops beating.
   B. Respirator/ventilator – used if unable to breathe on your own.
   C. Artificial nutrition (liquid food delivered by tube if unable to eat food).
   D. Artificial hydration (delivered into the vein if unable to drink fluids).
   E. Kidney dialysis – used if your kidneys stop working.

2. Do you want to donate parts of your body to someone in need at the time of your death (Organ Donation)?

3. How important is independence and self-sufficiency in your life? (Ability to communicate, perform personal hygiene, ability to move independently, to be aware and interactive with people and surroundings).

4. What will be important to you when you are dying (e.g. physical comfort, no pain, family members present, etc.)?

5. How do you feel about the use of life prolonging measures in the face of (1) terminal illness, (2) persistent vegetative state (Karen Ann Quinlan), (3) Alzheimer's Disease, (4) chronic neurologic disorders?

6. Do you wish to make any general comments about your attitude toward illness, dying and death?

7. How do your religious beliefs affect your attitude and decisions regarding medical treatment?

8. Do you expect that your friends, family and/or others will support your decisions regarding medical treatment?

9. What does the phrase "*meaningful quality of life*" mean to you?

10. Where would you prefer to die, provided care could be provided and family/caring others would not be burdened?

If over time, your beliefs, and/or decisions change, you should inform your health care representative, physician, and make appropriate changes on your Advance Directive or execute a new document and distribute the updated version to the appropriate individuals.

SHORE | MEDICAL CENTER

Somers Point, NJ 08244

PATIENT ID/LABEL HERE:
Name: ________________________________
Date of Brith: ____________________________
Address: _______________________________
____

ADVANCE DIRECTIVE / LIVING WILL

The decision to fill out an advance directive is completely your choice. Your medical care does not depend upon whether or not you complete an advance directive. Please consider your advance directive choices carefully. It is important that you fully understand its meaning and what treatment you will receive as a result. Please note that this form goes into effect only if you are unable to communicate for yourself. You will be involved in your healthcare decisions unless you lose the capacity to do so. You may modify this document to fit your healthcare needs.

A. I, ______________________________, being of sound mind willfully and voluntarily make this statement to be followed if I become unable to speak for myself. This document reflects my desires regarding life sustaining treatment.

Please initial the statement with which you agree: (SELECT ONE, but not both):

B. LIFE-SUSTAINING TREATMENT. If I should suffer from severe and irreversible brain damage, brain disease or an end stage medical condition with no realistic hope of return to my previous quality of life, I direct that treatment be limited to measures to keep me comfortable and to relieve pain. I would consider such a state unacceptable and the use of aggressive medical care to be burdensome.

1. To clarify my wishes I direct my resuscitation status (Code status) to be Do No Resuscitate (DNR). This would include:
   _____ No electrical or mechanical intervention of my heart when it has stopped beating.
   _____ No tube feedings when I am no longer able to swallow.
   _____ No mechanical respiration by a ventilator when my body can no longer sustain my independent breathing.

   (**Please initial**) I agree _________

2. I direct that all measures and/or treatments be provided to prolong my life regardless of my condition. I direct my resuscitation status (Code status) to be Full Code.

   (**Please initial**) I agree _________

C. HEALTHCARE AGENT. I designate ________________________ phone _______________ residing at _______________________________________ as my Healthcare Agent to make medical treatment decisions for me when I can no longer speak for myself. If the person designated as my Healthcare Agent is not able to act, I designate ___________________, phone ______________ currently residing at ____________________________.

D. I have read and understand the contents of this document. I have discussed this Living Will and my thoughts with my family and healthcare agent. I am emotionally and mentally competent to make this declaration.

Signature ____ Date: _____________________

STATEMENT OF WITNESSES

I declare that the person who signed or acknowledged this document has (1) identified himself or herself to me (2) signed or acknowledged this document in my presence, (3) appears to be of sound mind, and under no duress, fraud or undue influence. I am not the person appointed as Healthcare Agent or Alternate by this document.

Sign & Print: (Under NJ Law, you must have 2 witnesses or a notary to make this form valid)

Witness Signature: ____________________________Address ____
Witness Signature: ____________________________Address ____

Notary Optional