GUIDELINES FOR COMPLETING THE NEW JERSEY ADVANCE DIRECTIVE FOR HEALTH CARE (LIVING WILL)

Prior to executing a New Jersey Advance Directive for Health Care (commonly known as a Living Will) and the Durable Power of Attorney For Health Care for the Appointment of a Health Care Representative (Proxy Directive), you should consult with your physician, hospital, family and become fully informed about your rights regarding medical treatment, the procedures and options available and all matters related to these important legal documents and their consequences.

After a full understanding, you may complete the document by printing your name on the top line of the document in the space provided for that purpose.

Under the headings A – TERMINAL CONDITIONS, B – PERMANENTLY UNCONSCIOUS and C – INCURABLE AND IRREVERSIBLE CONDITIONS THAT ARE NOT TERMINAL you should denote your preferences regarding treatment by marking a check or an (X) after number 1 if you wish to direct the withholding or discontinuation of medical treatment. If you wish to direct the continuation of life-sustaining treatment you must mark a check or an (X) on the space after the number 2.

Under the heading D- EXPERIMENTAL AND/OR FUTILE TREATMENT, you may mark a check or make an (X) in the space marked 1 only if you want this form of therapy or treatment withheld or withdrawn.

The heading E – BRAIN DEATH provides you with the option of excluding your death from being declared on the basis of the irreversible cessation of the entire brain, including the brain stem.

The heading F – SPECIFIC PROCEDURES AND/OR TREATMENTS provides you with the opportunity to express your desire and wishes regarding some specific medical treatment options. Should you want a particular treatment you should mark a check or make an (X) following the words: "I do want." Should you oppose a particular treatment or procedure, mark a check or make an (X) following the words: "I do not want."

The heading G – ORGAN DONATION provides you with the choice of donating your organs or not. Should you wish to donate your whole body to science for research or give any specific instructions regarding organ donations, you may write those directions in the box labeled specific instructions.

Under the heading for SPECIFIC INSTRUCTIONS there is a boxed space that enables you to write any wishes, directions and instructions that you wish to add to the document. This space enables you to craft the document to address your personal philosophy, value system, religious concerns and any other instructions.

The heading DURABLE POWER OF ATTORNEY FOR HEALTH CARE for the APPOINTMENT of a HEALTH CARE REPRESENTATIVE (PROXY DIRECTIVE),

provides you with a legal document that enable your to appoint a primary representative and an alternate health care representative authorized to make decisions regarding your health care and treatments consistent with your wishes as expressed in the instruction directive.

Please note that you should discuss your health care wishes with your selected representatives and that they should consent to serve as your proxies.

This document can be completed by dating the section that follows the sentence: "I sign this document knowingly and after careful deliberation" this day, month and year and by signing your name and printing your address.

Your signature must be done in front of two witnesses **OR** a notary. It does not require both. The hospital can usually provide a notary during week day hours. If you are using witnesses, they cannot be listed in the document. They can be other family members, neighbors or friends.

When you have completed your Advance Directive make several copies. Keep the original document in a safe but easily accessible place and tell others where you have it stored. DO NOT KEEP YOUR ADVANCE DIRECTIVE IN A SAFE DEPOSIT BOX and have it readily available upon admission to a hospital or nursing facility. Give copies of your Advance Directive to the individuals you have chosen to be your Health Care Representative and Alternate Health Care Representative. You may also give copies of your Advance to your doctor, your family, clergy and to anyone who might be involved with your health care.

New Jersey Advance Directive for Health Care
(Living Will)

** I, _____ (print your name), being of a sound mind and a competent adult knowing my right regarding medical care and treatment, do hereby execute this legally binding document expressing my wishes and directions to my family and health care providers of the treatment and care that I desire in the event that I am prevented by either physical or mental incapacity from making future medical decisions.

A - Terminal Condition

If I am diagnosed as having an incurable and irreversible illness, disease or condition and if my attending physician an at least one additional physician who has personally examined me determines that my condition is terminal:

1. _____ I direct that life-sustaining treatment which would serve only to artificially prolong my dying be withheld or ended. I also direct that I be given all medically appropriate treatment and care necessary to make me comfortable and to relieve pain.

2. _____ I direct that life-sustaining treatment be continued, if medically appropriate.

B – Permanently Unconscious

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 ability to interact with other people and my surroundings:

1. _____ I direct that life-sustaining treatment 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 treatment and care necessary to provide for my personal hygiene and dignity.

2. _____ I direct that life-sustaining treatment be continued, if medically appropriate.

C – Incurable and Irreversible Conditions that are not Terminal

If there comes a time when I am diagnosed as having an incurable and irreversible illness, disease or condition which may not be terminal, but causes me to experience severe and physical or mental deterioration and I will never regain the ability to make decision and express my wishes:

1. _____ I direct that such life-sustaining treatment be withheld or withdrawn. I also direct that I be given all medically appropriate care necessary to make me comfortable and to relieve pain.

2. _____ I direct that life-sustaining treatment be continued.

D – Experimental and/or Futile Treatment

If I am receiving life-sustaining treatment that is experimental and not a proven therapy, or is likely to be ineffective or futile in prolonging life:

1. _____ I direct that such life-sustaining treatment be withheld or withdrawn. I also direct that I be given all medically appropriate care necessary to make me comfortable and to relieve pain.

E – Brain Death

The State of New Jersey has enacted legislation that has determined that an individual may be declared legally brain dead when there has been an irreversible cessation of all the functions of the brain, including the brain stem (this is also known as whole brain death). However, should this definition interfere with personal religious beliefs of individuals, they may request that it not be applied.

1. _____ To declare my death on the basis of the whole brain death standard would violate my personal beliefs. I therefore wish my death to be declared only when my heartbeat and breathing have irreversibly stopped.

F – Specific Procedures and/or Treatments

If I am in any of the conditions described above, I feel especially strong about the following forms of treatment:

I do want_____	I do not want_____ cardiopulmonary resuscitation
I do want_____	I do not want_____ mechanical respiration
I do want_____	I do not want_____ tube feeding
I do want_____	I do not want_____ antibiotics
I do want_____	I do not want_____ maximum pain relief
I do want_____	I do not want_____ kidney dialysis

I do want_____ I do not want_____ surgery (such as amputation)
I do want_____ I do not want_____ blood transfusion
I do want_____ I do not want_____ to die at home

G – Organ Donation

I do want_____ I do not want_____ to donate my organs

SPECIFIC INSTRUCTIONS

(Please write in your own hand your end of life instructions, directions and treatment preferences and sign your signature.)

HIPAA PROVISION IN MEDICAL DIRECTIVES

The Medical Decision Attorney-in-Fact named in this document is hereby designated as my "Personal Representative" as DEFINED BY 45 CFR 164.502 (g), commonly known as the HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT of 1996 (HIPAA). This individual is to have the same access to my health care and treatment information as I would have if I were able to act for myself. My Medical Decision Attorney-in-Fact and Personal Representative named herein is also authorized to take any and all legal steps necessary to ensure his or her access to information and such action shall include resorting to legal process, if necessary, to enforce my rights under the law and shall attempt to recover attorneys fees as authorized by New Jersey law, in enforcing my rights. _____

Signature

Durable Power of Attorney for Health Care for the Appointment of a Health Care Representative
(Proxy Directive)

*** I_____ (print name here) do hereby appoint:
(Name)_____(City)_____(State)_____
(Zip)_____

to be 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 treatment if I am unable to make such decision myself. I direct my health care 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 if a situation arises that I did not anticipate my health care representative is authorized to make decisions in my best interest.

If the previously named person is unable, unwilling, or unavailable to act as my health care representative, I appoint the following as my alternate health care representative:

Name _____ Telephone _____
Address _____
City _____ State _____ Zip Code _____

I sign this document knowingly and after careful deliberation this _____ day of _____, 20_____.

** Signature _____
Address _____
City _____ State _____ Zip Code _____

Witnesses:

Witness Signature _____ Witness Name (print) _____
Address _____
City _____ State _____ Zip Code _____

Witness Signature _____ Witness Name (print) _____
Address _____
City _____ State _____ Zip Code _____

Sworn and Subscribed before me on the _____ day of _____, 20_____

_____
Notary Public – State of New Jersey

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTHCARE PROFESSIONALS AS NECESSARY

NEW JERSEY PRACTITIONER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)

Follow these orders, then contact physician/APN/PA. This Medical Order Sheet is based on the current medical condition of the person referenced below and their wishes stated verbally or in a written advance directive. Any section not completed implies full treatment for that section. Everyone will be treated with dignity and respect.

Person's Name (last, first, middle) Date of Birth

Print Person's Address

A

GOALS OF CARE *(See reverse for instructions. This section does not constitute a medical order.)*

B

MEDICAL INTERVENTIONS *Person is breathing and/or has a pulse*

❒ **Full Treatment.** Use all appropriate medical and surgical interventions as indicated to support life. If in a nursing facility, transfer to hospital if indicated. See section D for resuscitation status.

❒ **Limited Treatment.** Use appropriate medical treatment such as antibiotics and IV fluids as indicated. May use non-invasive positive airway pressure. Generally avoid intensive care.

❒ Transfer to hospital for medical interventions. ❒ Transfer to hospital only if comfort needs cannot be met in current location.

❒ **Symptom Treatment Only.** Use aggressive comfort treatment to relieve pain and suffering by using any medication by any route, positioning, wound care and other measures. Use oxygen, suctioning and manual treatment of airway obstruction as needed for comfort. Use antibiotics only to promote comfort. Transfer only if comfort needs cannot be met in current location.

Additional Orders: _____

C

ARTIFICIALLY ADMINISTERED FLUIDS AND NUTRITION *Always offer food/fluids by mouth, if feasible and desired*

❑ No artificial nutrition ❑ Long-term artificial nutrition ❑ Defined trial period of artificial nutrition

D

CARDIOPULMONARY RESUSCITATION (CPR)

Person has no pulse and/or is not breathing

❑ Attempt resuscitation/CPR

❑ Do not attempt resuscitation/DNAR
Allow Natural Death

AIRWAY MANAGEMENT *Person is in respiratory distress with a pulse*

❑ Intubate/use artificial ventilation as needed

❑ Do not intubate - Use O2, manual treatment to relieve airway obstruction, medications for comfort

❑ Additional Order (for example defined trial period of mechanical ventilation)

_____

_____

E

If I lose my decision-making capacity, I authorize my surrogate decision-maker, listed below, to modify or revoke the NJ POLST orders in consultation with my treating physician/APN/PA in keeping with my goals: ❑ Yes ❑ No

F

SIGNATURES

I have discussed this information with my physician/APN/PA

_____
Print Name

_____
Signature

❑ Person Named Above ❑ Spouse/Civil Union Partner

❑ Health Care Representative/ Legal Guardian ❑ Parent of Minor

❑ Other Surrogate

Has the person named above made an anatomical gift:
❑ Yes ❑ No ❑ Unknown

These orders are consistent with the person's medical condition, known preferences and best known information.

_____
PRINT - Physician/APN/PA Name Phone Number

_____
Physician/APN/PA Signature (Mandatory) Date/Time

_____
Professional License Number

SURROGATE INFORMATION

Surrogate listed here is the healthcare representative previously identified in an advance directive: ❑ Yes ❑ No ❑ Unknown

_____
Print Name of Surrogate Phone Number

_____
Print Surrogate Address

■ **Surrogate listed is only authorized to change this form if "yes" is checked in Section E above.**

DIRECTIONS FOR HEALTHCARE PROFESSIONAL

COMPLETING POLST

- Must be completed by a physician, advance practice nurse or physician assistant.
- Use of original form is strongly encouraged. Photocopies and faxes of signed POLST forms may be used.
- Any incomplete section of POLST implies full treatment for that section.

REVIEWING POLST

POLST orders are actual orders that transfer with the person and are valid in all settings in New Jersey. It is recommended that POLST be reviewed periodically, especially when:

- The person is transferred from one care setting or care level to another, or
- There is a substantial change in the person's health status, or
- The person's treatment preferences change.

MODIFYING AND VOIDING POLST – *An individual with decision-making capacity can always modify/void a POLST at any time.*

- A surrogate, if authorized in Section E on the front of this form, may, at any time, void the POLST form, change his/her mind about the treatment preferences or execute a new POLST document based upon the person's known wishes or other documentation such as an advance directive.
- A surrogate decision-maker, if authorized on this form to do so, may request to modify the orders based on the known desires of the person or, if unknown, the person's best interests.
- To void POLST, draw a line through all sections and write "VOID" in large letters. Sign and date this line.

Section A

What are the specific goals that we are trying to achieve by this treatment plan of care? This can be determined by asking the simple question: "What are your hopes for the future?" Examples include but are not restricted to:

- Longevity, cure, remission
- Better quality of life
- Live long enough to attend a family event (wedding, birthday, graduation)
- Live without pain, nausea, shortness of breath
- Activities such as eating, driving, gardening, enjoying grandchildren

Medical providers are encouraged to share information regarding prognosis to enable the person to set realistic goals.

Section B

- When "limited treatment" is selected, also indicate if the person prefers or does not prefer to be transferred to a hospital for additional care.
- IV medication to enhance comfort may be appropriate for a person who has chosen "symptom treatment only."
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP) or bi-level positive airway pressure (BiPAP).
- Comfort measures will always be provided.

Section C

Oral fluids and nutrition should always be offered if medically feasible and if they meet the goals of care determined by the person or surrogate. The administration of nutrition and hydration whether orally or by invasive means shall be within the context of the person's wishes, religion and cultural beliefs.

Section D

Make a selection for the person's preferences regarding CPR and a separate selection regarding airway management. A defined trial period of mechanical ventilation may be considered, for example, when additional time is needed to assess the current clinical situation or when the expected need would be short term and may provide some palliative benefit.

Section E

This section is applicable in situations where the person has decision-making capacity when the POLST form is completed. A surrogate may only void or modify an existing POLST form, or execute a new one, if authorized in this section by the person.

Section F

POLST must be signed by a practitioner, meaning a physician, APN or PA, to be valid. Verbal orders are acceptable with follow-up signature by the physician/APN/PA in accordance with facility/community policy. POLST orders should be signed by the person/surrogate. Indicate on the signature line if the person/surrogate is unable to sign, declined to sign, or a verbal consent is given. Remind the person/surrogate that once completed and signed, this POLST will void any prior POLST documents.