Atlantic
Health System

DT202

PATIENT ID
HERE

ADVANCE DIRECTIVE FOR HEALTH CARE

INSTRUCTION DIRECTIVE

An **Instruction Directive for Health Care,** sometimes called a **Living Will,** is a written document, signed by you, in which you decide the kind of care you would want, if for any reason you are unable to make health care decisions for yourself.

You do not need to have a Living Will, but having one will avoid many problems. It will let your physician, family, and friends know ahead of time what kind of decisions should be made for you if you become disabled, physically or mentally, and are unable to decide for yourself. You will receive appropriate medical care whether or not you have an Advance Directive.

PROXY DIRECTIVE-
DURABLE POWER OF ATTORNEY FOR HEALTH CARE

In addition to your Instruction Directive, we encourage you to fill out a **Proxy Directive** in which you designate a health care representative, for example, a family member, friend, or other person who understands your feelings and is willing to make decisions for you about accepting, refusing, or withdrawing treatment if you become unable to do so for yourself.

***

This four-page document includes a list of definitions and the above two types of Advance Directives (together called a **Combined Directive**). Some people choose to fill out only one of these forms. We recommend that you fill out both.

Before filling out these forms, you are encouraged to speak with your doctor, family, health care representative, or others who may become responsible for following your wishes. Once you sign and date these forms and have them witnessed by two individuals, your requests must be followed by anyone involved in your care, but only at a time when you are not capable of making decisions for yourself.

After you fill out your Advance Directive, we recommend that you keep the original and give copies to your appointment health care representative, your physician, and any other family member, close friend, or advisor who is interested in your health and well-being.

Written and approved by the Medical Society of New Jersey 7/95.

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TERMS YOU SHOULD UNDERSTAND

A. Life-Sustaining Treatment

1. *Cardiopulmonary Resuscitation (CPR).* CPR describes procedures that are done to restart the heart when it stops beating ("cardiac arrest"), and/or to provide artificial respiration when breathing stops ("respiratory arrest"). CPR can involve manual pressure to the chest and mouth-to-mouth breathing or pumping of air into the lungs using a rubber bag. In some instances, a tube may be inserted into the windpipe ("intubation") for mechanical ventilation.

2. *Mechanical Ventilation or Respiration.* A machine called a respirator or ventilator can take over breathing if the lungs cannot adequately breathe. It provides oxygen through a tube inserted into the windpipe.

3. *Surgery.* A surgical procedure involves cutting into the body to treat a problem.

4. *Chemotherapy.* Chemotherapy is drug treatment for cancer. It is used to cure cancer or reduce the discomfort of cancer even if it does not cure it.

5. *Radiation Therapy (RT).* RT involves the use of high levels of radiation to shrink or destroy a tumor.

6. *Dialysis.* Dialysis requires the use of a machine that cleanses the blood when the kidneys cannot function adequately. This can be done through tubes placed into blood vessels (hemodialysis) or through tubes into the abdomen (peritoneal dialysis).

7. *Transfusion.* The transfusion refers to the giving of any type of blood product into a vein intravenously.

8. *Artificially Provided Nutrition and Fluids.* This group of terms refers to feeding patients who are unable to swallow food and fluid. This can be done through a tube into a vein or into the stomach. The feeding tube to the stomach can be placed through the nose (nasogastric tube) or through the abdomen (gastrostomy tube.)

9. *Antibiotics.* Antibiotics are medications used to fight infections. They can be administered by mouth,by vein, by injection into a muscle, or through a feeding tube.

B. Comfort and Supportive Care (Palliative Care)

Comfort care is any kind of treatment that increases a person's physical or emotional comfort. Comfort care includes adequate pain control. It may also include oxygen, food and fluids by mouth, moistening of the lips, cleaning, turning, touching a person, or simply sitting with someone who is bedridden.

C. Medical Conditions

1. *Terminal Condition.* The end stage of an irreversibly fatal illness, disease, or condition.

2. *Permanent Unconsciousness.* A medical condition that is total and irreversible in which a person cannot interact with his/her surroundings or with others in any way and in which a person does not experience pleasure or pain

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INSTRUCTION DIRECTIVE
(Living Will)

To My Family, Doctors, and All Those Concerned with My Care:

I, _____, being of sound mind, make this statement as a directive to be followed if for any reason I become unable to participate in decisions regarding my medical care (Initial any that apply.)

A. _____ 1. I direct that life-sustaining procedures be withheld or withdrawn a) if I become permanently unconscious, b) if I have a terminal illness, c) if I experience extreme mental deterioration, or d) if I have another type of irreversible illness. The above conditions shall have no reasonable expectation of recovery or chance of regaining a meaningful quality of life. These medical conditions shall be determined by my attending physician and at least one additional physician. I understand that I will be kept comfortable.

OR

_____ 2. I direct that all medically appropriate measures be provided to sustain my life. regardless of my physical or mental condition.

B. This section asks you to think about the values that are important to you regarding treatment in case of severe mental or physical illness.

_____ 1. I do not wish my life to be prolonged by medical treatment(s) if my quality of life is unacceptable to me. The following are conditions that are **unacceptable** to me. (Initial only those that describe a way of living that you could not tolerate):

_____ a) Permanently unconscious with a ventilator breathing for me.

_____ b) Permanently unconscious with a feeding tube and/or intravenous (IV) hydration.

_____ c) On a ventilator when there is little or no chance of recovery.

_____ d) Being conscious (awake), but unable to communicate (for example, with a stroke), and being fed with a feeding tube and/or hydrated with IVs to keep me alive.

_____ e) Living with a dementia like Alzheimer's disease so severe that I am unable to recognize those who love me.

OR

_____ 2. I want to live as long as possible, regardless of the quality of life that I experience.

C. If you choose A. 1., above, the life-sustaining procedures that would be withheld or withdrawn include but are not limited to: CPR, mechanical ventilation, surgery, chemotherapy, radiation, dialysis, transfusion, and antibiotics. Initial the following if it applies to you (see "Terms You Should Understand")

_____ In the circumstances described in A.1., above, I also direct that artificially provided nutrition and fluids be withheld and withdrawn and that I be allowed to die.

D. _____ Upon my death, I am willing to donate any parts of my body that may be beneficial to others.

Additional Comments or Exceptions: _____

_____

These directions express my legal right to request or refuse treatment. Therefore, I expect my family, doctor, and all those concerned with my care to regard themselves as legally and morally bound to act in accord with my wishes.

Signed _____ **Date** _____

Witnesses (cannot be health care representative or alternative representative if any are named on the other side of this page). I declare that the person who signed this document, or asked another to sign this document on his/her behalf, did so in my presence and that he/she appears to be of sound mind and free of duress or undue influence.

Witness _____ **Date** _____

Witness _____ **Date** _____

Reminder: Give a copy of this document to your doctor, health care representative, and other concerned individuals.

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DURABLE POWER OF ATTORNEY FOR HEALTH CARE
(Proxy Directive)

If you wish, you may use this section to designate someone to make treatment decisions if you are unable to do so. Your Living Will declaration will be in effect even if you have not designated a proxy.

I, _____, designate the following person as my health care representative to make any and all health care decisions for me acting in my best interest, in the event that i become incapable of making decisions for myself.

Name _____ **Relationship** _____

Street _____

City _____ **State** _____ **Telephone** _____

If the person I have named above is unable to act as my health care representative, I hereby designate the following person(s) to do so:

1. **Name** _____ **Relationship** _____

   Street _____

   City _____ **State** _____ **Zip** _____ **Telephone** _____

2. **Name** _____ **Relationship** _____

   Street _____

   City _____ **State** _____ **Zip** _____ **Telephone** _____

SPECIFIC DIRECTIONS: Please initial the statement below that best expresses your wishes.

_____ My health care representative is authorized to direct that artificially provided fluids and nutrition, such as by feeding tube or IV infusion, be withheld or withdrawn.

_____ My health care representative does not have this authority, and I direct that artificially provided fluids and nutrition be provided to preserve my life, to the extent medically appropriate.

Signed _____ **Date** _____

Witnesses (cannot be health care representative or alternative representative listed above.)

I declare that the person who signed this document, or asked another to sign this document on his/her behalf, did so in my presence and that he/she appears to be of sound mind and free of duress or undue influence.

Witness _____ **Date** _____

Witness _____ **Date** _____

***Reminder: Give a copy of this document to your doctor, health care representative, and other concerned individuals.**

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.**

SEND ORIGINAL FORM WITH PERSON, WHENEVER TRANSFERRED

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.