ADVANCE DIRECTIVE FOR HEALTHCARE *(cont.)*

(Living Will and Health Care Representative)

E. **Substitute Representative**

If the person I have chosen above is unable to act as my Health Care Representative, I choose the following person(s) to do so.

1. Name _____ Relationship _____
Street _____
City _____ State _____
Telephone Numbers (Please include daytime, work, evening and cell phone numbers)
_____

1. Name _____ Relationship _____
Street _____
City _____ State _____
Telephone Numbers (Please include daytime, work, evening and cell phone numbers)
_____

F. **I have discussed my wishes with the people listed above and trust their judgment concerning my welfare and wishes. I understand this document, and I sign it knowingly, willingly and after careful thought. (Sign only in the presence of two witnesses or a notary.)**

_____
Signature Date

_____
Birth Date Social Security Number

G. **Witnesses (cannot be health care representative or substitutes listed in D or E)**

I declare I witnessed the person who signed this document and he or she understands this document and what it means. ***(Under New Jersey law, you must have either two witnesses or a notary to make this form valid.)***

Sign and Print Name:
Witness _____ Date _____
Address _____
Witness _____ Date _____
Address _____

NOTARY *(optional)*

Bacharach
INSTITUTE FOR REHABILITATION

61 W. Jimmie Leeds Road Pomona, New Jersey 08240
609-652-7000 ext. 5577 www.bacharach.org

Advance directives, which include both "Living Wills" and a document to appoint a Health Care Representative, (some times referred to as a Health Care Proxy, Health Care Power of Attorney or Health Care Decision maker), have been recognized by New Jersey Law for more than a decade. At Bacharach Institute for Rehabilitation we support your right to control decisions about your health care. If a time comes when you become unable to make your own health care decisions, you can choose to express your wishes by completing an advance directive.

As part of our responsibilities under the law, we are required to provide community information and education on advance directives. A copy of the Bacharach advance directive is available by going to our website at www.Bacharach.org and selecting services, at the bottom of the page there is a link to the Bacharach advance directive. If you need help, we would be happy to assist you. We suggest that you review the advance directive packet and discuss your thoughts and feelings about your health care decisions with your family, your doctors, and perhaps a spiritual person in your life. If you have any questions or need help completing an advance directive, you can call the following people at Bacharach Institute for Rehabilitation.

Dr. Melanie Wilson Silver (609) 652-7000, Ext. 5577
Beth Hoffman (609) 748-2081
Case Management (609) 748-2082

ADVANCE DIRECTIVE *Things to Consider*

The Bacharach advance directive form is one of many that are available. Any type of form can be used as long as it conforms to state law and the requirements listed below.

You need to be 18 years old and able to understand the consequences of your healthcare decisions to complete an advance directive. Parents cannot fill out an advance directive for their children.

You cannot complete an advance directive on behalf of another person. However, you can assist in recording another person's decisions if they have difficulty writing. The person would need to be able to sign and date the document.

You don't need to go to a lawyer to complete an advance directive, unless you choose to do so.

The choice to complete an advance directive is completely voluntary. It is illegal to require patients to have one, or condition care upon having an advance directive. Having an advanced directive is a way to safeguard your right to make treatment decisions and a way for health care providers to respect your preferences.

You may choose to have a "living will", which is an instructional directive, or a "proxy directive" in which you appoint a person to express your health care decisions, (or make health care decision on your behalf), or a "combined directive" in which you include both an instructional directive and a "proxy directive".

You should discuss your healthcare preferences with your physicians prior to completing an advance directive. Your physician may raise questions that you may not have considered.

Advance directives in New Jersey require EITHER two witnesses OR a notary to be valid. You may choose to have both, especially if you travel to another state obtain health care.

You should ask the person you want to be your healthcare representative if they are willing before you name them in the advance directive. You should discuss your preferences with them so they understand what decisions you would make, if you could and why. It may help to choose some one who has a similar philosophy to you. However, your healthcare representative does not have to agree with your decisions, but does need to be able to respect them.

The person that you designate to be your healthcare representative in your "proxy directive" cannot be a witness to your advance directive. Your treating or attending physician cannot be your health care representative and still remain your treating or attending physician.

The healthcare representative should place his or her phone numbers, (home, work and cell) and contact information on the advance directive, so if the need arises he or she can be easily reached.

When you complete an advance directive, keep the original and make copies to give to your health care representative, physicians and any health care facility to which you are admitted. A copy or fax is recognized to be as valid as the original; you do not need a raised seal. If you choose to use the Bacharach form, it is a good idea to make double-sided copies of it, to minimize any risk of loosing part of the document.

Your advance directive becomes operative when your physician has received it. For a health care facility to honor your wishes, you must ensure that a copy is given to them.

We follow your advance directive when you cannot speak, when you are no longer able to make informed decisions about your medical treatment AND your physician has determined that you meet the conditions stated in the advance directive, which may include:

No reasonable expectation of recovery; The condition is irreversible; The condition is terminal; There is no reasonable expectation of the patient regaining a meaningful quality of life, as defined by you.

It is very important to note that having an advance directive does not mean that you will not be resuscitated, even if you decline resuscitation in the advance directive. If a person suffers a cardiopulmonary arrest we would not resuscitate him, if and only if, he meets criteria set out in the advance directive. In the majority of circumstances, we will not be able to determine if the person has met the criteria in the advance directive unless they are assessed, evaluated and treated first. In practical terms this means that you will be resuscitated and put on a ventilator, if your medical condition requires it, while this assessment is carried out. Once it has been ascertained that you meet the criteria in your advance directive, all and any treatment can be withdrawn.

If you are completely sure that you don't want to be resuscitated were your heart to stop beating, regardless of the likelihood of recovery, you need to ask your physician to write a 'No Code Order', or a DNR – 'Do not Resuscitate Order'. This order indicates to the staff that you have declined resuscitation regardless of your condition while in the hospital. If you do not want to be resuscitated outside the hospital were your heart to stop beating, regardless of the likelihood of recovery, you need to ask your physician to write an 'Out of Hospital DNR Order'. This will ensure that if your heart were to stop beating while at home or in the community somewhere, were the emergency services to be summoned, having seen the 'Out of Hospital DNR Order', they would not initiate resuscitation. You would still receive all and any treatment in an emergency that was not part of cardiopulmonary resuscitation; even if you have an 'Out of Hospital DNR Order'.

Over time your feelings and preferences might change regarding the treatment you may or may not find acceptable. It is a good idea to review your advance directive annually and make changes as necessary. It is also recommended that you date and initial below the signature line each year to indicate that the content of your advance directive has been reviewed and is still current. After you have made changes or executed a new advance directive, make sure that the old advance directive is destroyed and distribute the new one to your health care representative, your doctors and family members.

You may rescind or change your advance directive at any time regardless of whether you are competent. This may be indicated either verbally or non-verbally.

Bacharach
INSTITUTE FOR REHABILITATION
61 W. Jimmie Leeds Road Pomona, New Jersey 08240
609-652-7000 ext. 5577 www.bacharach.org

ADVANCE DIRECTIVE FOR HEALTHCARE

(Living Will and Health Care Representative)

This advance directive form is one of many that meet New Jersey State criteria. The decision to fill out an advance directive is completely your choice. Your medical care does not depend on whether or not you complete an advance directive. You cannot be forced to complete one, although it is a good idea and a way for your family and health care providers to respect your right to make treatment decisions. 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 of it. ***Please note that this form and the decisions you make on it only go in to effect if you are unable to communicate for yourself and you meet the criteria in the document. You will be involved in your health care decisions unless you lose the capacity to do so.***

To my family, my doctors, and others concerned with my care:

A. I, _____ , being of sound mind, make known my instructions for my health care treatment should I become unable to make decisions about my care.

B. Please initial the statement with which you agree: (select one, but not both)
(Please note that regardless of your choice below, you will receive treatment to relieve pain and to keep you comfortable).

1. _____If my condition becomes so serious that there is no reasonable chance of recovery or regaining a meaningful quality of life, then life-prolonging measures should not be started or if they have been, they should be stopped. Those life-prolonging procedures or treatments that may be stopped include, for example: ventilator/respirator, chest compressions, defibrillation (electric shocks to restart your heart) and rescue breathing, artificially administered fluids and nutrition, and dialysis.

2. _____I direct that all measures and/or treatments are provided to prolong my life regardless of my condition.

C. Additional Comments or Instructions

_____
_____
_____

D. **Appointing a Health Care Representative: I appoint:**
Name _____ Relationship _____
Street _____
City _____ State _____
Telephone Numbers (Please include daytime, work, evening and cell phone numbers)
_____
_____

My health care representative will have the authority to decide about accepting, refusing or stopping treatment in accordance with my wishes, as stated in this document and as known by this health care representative, from what I have said in the past. In addition, my representative will have the authority to choose the physicians who will care for me, and will be able to access my medical records and disclose this information to others. In the event my wishes are not clear, or a situation occurs that I did not plan for, my health care representative is directed to make decisions in my best interest, based upon what he or she knows of my wishes and what is important to me.