



Healthcare System Inc.

St. Joseph's Regional Medical Center
St. Joseph's Wayne Hospital
St. Vincent's Nursing Home
Visiting Health Services of NJ

ADVANCE DIRECTIVE FOR HEALTH CARE

St. Joseph's is a Catholic Healthcare System that holds as a primary value the need to respect life at every stage and in every condition. The Healthcare System also encourages active participation of patients in a shared decision making process regarding their care.

An Advance Directive can help assure that your wishes regarding health care are respected even if there comes a time when you are no longer able to participate in decisions about your care.

This is one of many Advance Directive forms that are available; others are equally valid. You may complete one or both parts of this form. Part A is a Living Will which is a statement expressing what types of treatment you would or would not want a health care provider or institution to provide, as well as any health care instructions you want known if you cannot speak or communicate for yourself. Part B is a designation of a Health Care Representative. By completing Part B, you can choose and appoint someone to make medical decisions for you in case you are unable to communicate for yourself. The individual appointed shall be obligated to follow the Instruction Directives in Part A if Part A is completed.

Part A) INSTRUCTION DIRECTIVES (Living Will)

In Part A you are asked to provide instructions concerning your health care. This requires making important choices that you may want to discuss with your doctor, family member, and your Health Care Representative.

To my Family, Doctors and all those concerned with my care:

I, \_\_\_\_\_, being of sound mind, hereby declare and make known my instructions and wishes for future health care in the event that for any reason due to physical or mental incapacity, I am unable to participate in decisions regarding my care.

Please initial one of the following statements with which you agree.

\_\_\_ I direct that all medically appropriate measures be provided to sustain my life, regardless of my physical or mental condition. Futile treatment is always considered medically inappropriate.

\_\_\_ I direct that life-sustaining treatment be withheld or withdrawn if I have an illness, disease or injury, or experience extreme mental deterioration, such that there is no reasonable expectation of recovering or regaining a meaningful quality of life. These life-sustaining treatments that may be withheld or withdrawn include, but are not limited to, Surgery, Drugs, Cardiac Resuscitation, Respiratory Support, and Artificially Administered Feeding and Fluids. I direct that I be given only appropriate medical care to alleviate pain and keep me comfortable.

Additional Comments or Instructions (optional): \_\_\_\_\_

Three horizontal lines for additional comments or instructions.

**Part B) DESIGNATION OF A HEALTH CARE REPRESENTATIVE** (Durable Power of Attorney for Health Care or Health Care Proxy)

*In Part B you may designate an individual you trust to act as your legally recognized Health Care Representative to make health care decisions for you in the event you are unable to make them yourself. You may also designate an alternate representative.*

**I hereby designate:**

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Name	Relationship
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Street
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City	State	Telephone
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as my Health Care Representative to make decisions about accepting, refusing or withdrawing treatment in accordance with my wishes as stated in this document. In the event my wishes are not clear, or a situation arises that I did not anticipate, my Health Care Representative is authorized to make decisions in my best interest, based upon what is known of my wishes.

**Additional Comments or Instructions** *(optional)*:

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**Alternate Representative**

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 to do so:

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Name	Relationship
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Street
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City	State	Telephone
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**SIGNATURE AND WITNESSES**

**I understand the purpose of this document, and I sign it knowingly, voluntarily and after careful deliberation.**

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Signature	Date
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*Witnesses (cannot be my Health Care Representative or Alternate Representative designated above)*  
**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, and that he or she appears to be of sound mind and free of undue influence.**

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Signature	Date
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Signature	Date
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