Hunterdon Family Physicians
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☐ **I decline to fill out / provide this document.** Print name _____
Patient signature _____ Date _____ Date of Birth _____

Advance 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 and all 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 I direct that life-sustaining procedures be ***withheld*** or ***withdrawn:*** a) if I become permanently unconscious; b) if I have a terminal illness; c) if I experience extreme mental deterioration; or d) if I have another type of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 physicians and at least one additional physicians. 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 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 IV's 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C. If chose A. above, the life-sustaining procedures that would be withheld or withdrawn include but are not limited to: CPR, mechanical ventilation, surgery, chemotherapy, radiations, dialysis, transfusion, and antibiotics. *Initial the following if it applies to you.*
____ 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.

Sign_____ **Date of Birth**_____ **Date**_____

Witnesses *(cannot be health care representatives or alternate 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 Sign_____ **Date** _____

Witness Sign_____ **Date** _____

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