END-OF-LIFE CARE
Sample Documents

Provided by:

Gina L. Campanella, JD, MHA, CHA
Founder & Principal
Campanella Law Office LLC
glc@campanellalawnj.com
(201) 891-3726

For news, articles and alerts follow us on:

@CampanellaLawNJ  +Campanellalawnj
(201) 891-3726 * www.campanellalawnj.com
356 Franklin Avenue, 2nd Floor, Wyckoff, NJ & 43 West 43rd Street, Suite 143, New York, NY (Appointment Only)
INSTRUCTION DIRECTIVE

I understand that as a competent adult I have the right to make decisions about my health care. There may come a time when I am unable, due to physical or mental incapacity, to make my own health care decisions. In these circumstances, those caring for me will need direction concerning my care and they will require information about my values and health care wishes. In order to provide the guidance and authority needed to make decisions on my behalf:

A) I, __________________________, hereby declare and make known to my family, physician, and others, my instructions and wishes for my future health care. I direct that all health care decisions, including decisions to accept or refuse any treatment, service or procedure used to diagnose, treat or care for my physical or mental condition and decisions to provide, withhold or withdraw life-sustaining measures, be made in accordance with my wishes as expressed in this document. This instruction directive shall take effect in the event I become unable to make my own health care decisions, as determined by the physician who has primary responsibility for my care, and any necessary confirming determinations. I direct that this document become part of my permanent medical records.

Part One: Statement of My Wishes Concerning My Future Health Care

In Part One, you are asked to provide instructions concerning your future health care. This will require making important and perhaps difficult choices. Before completing your directive, you should discuss these matters with your doctor, family members or others who may become responsible for your care.

In Section B and C, you may state the circumstances in which various forms of medical treatment, including life-sustaining measures, should be provided, withheld or discontinued. If the options and choices below do not fully express your wishes, you should use Section D, and/or attach a statement to this document which would provide those responsible for your care with additional information you think would help them in making decisions about your medical treatment. Please familiarize yourself with all sections of Part One before completing your directive.

B) GENERAL INSTRUCTIONS: To inform those responsible for my care of my specific wishes, I make the following statement of personal views regarding my health care:

Initial ONE of the following two statements with which you agree:

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

2.  There are circumstances in which I would not want my life to be prolonged by further medical treatment. In these circumstances, life-sustaining measures should not be initiated and if they have been, they should be discontinued. I recognize that this is likely to hasten my death. In the following, I specify the circumstances in which I would choose to forego life-sustaining measures.
If you have initialed statement 2 on page 1, please initial each of the statements (a, b, c) with which you agree:

a. ______ I realize that there may come a time when I am diagnosed as having an incurable and irreversible illness, disease, or condition. If this occurs, and my attending physician and at least one additional physician who has personally examined me determine that my condition is terminal, I direct that life-sustaining measures which would serve only to artificially prolong my dying be withheld or discontinued. I also direct that I be given all medically appropriate care necessary to make me comfortable and to relieve pain.

In the space provided, write in the bracketed phrase with which you agree:

To me, terminal condition means that my physicians have determined that:

________________________________________________________________________________________
[I will die within a few days] [I will die within a few weeks]
[I have a life expectancy of approximately ______________ or less (enter 6 months, or 1 year)]

b. ______ If there should come a time when I come 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 capacity for interaction with other people and my surroundings, I direct that life-sustaining measures 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 my medically appropriate care necessary to provide for my personal hygiene and dignity.

c. ______ I realize that there may come a time when I am diagnosed as having an incurable and irreversible illness, disease, or condition which may not be terminal. My condition may cause me to experience severe and progressive physical or mental deterioration and/or a permanent loss of capacities and faculties I value highly. If, in the course of my medical care, the burdens of continued life with treatment become greater than the benefits I experience, I direct that life-sustaining measures be withheld or discontinued. I also direct that I be given all medically appropriate care necessary to make me comfortable and to relieve pain.

(Paragraph c. covers a wide range of possible situations in which you may have experienced partial or complete loss of certain mental and physical capacities you value highly. If you wish, in the space provided below you may specify in more detail the conditions in which you would choose to forego life-sustaining measures. You might include a description of the faculties or capacities, which, if irretrievably lost would lead you to accept death rather than continue living. You may want to express any special concerns you have about particular medical conditions or treatments, or any other considerations which would provide further guidance to those who may become responsible for your care. If necessary, you may attach a separate statement to this document or use Section D to provide additional instructions.)

Examples of conditions which I find unacceptable are:

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
C) SPECIFIC INSTRUCTIONS: Artificially Provided Fluids and Nutrition; Cardiopulmonary Resuscitation (CPR). On page 2 you provided general instructions regarding life-sustaining measures. Here you are asked to give specific instructions regarding two types of life-sustaining measures: artificially provided fluids and nutrition and cardiopulmonary resuscitation.

In the space provided, write in the bracketed phrase with which you agree:

1. In the circumstances I initialed on page 2, I also direct that artificially provided fluids and nutrition, such as by feeding tube or intravenous infusion,

   [be withheld or withdrawn and that I be allowed to die]
   [be provided to the extent medically appropriate]

2. In the circumstances I initialed on page 2, if I should suffer a cardiac arrest, I also direct that cardiopulmonary resuscitation (CPR)

   [not be provided and that I be allowed to die]
   [be provided to preserve my life, unless medically inappropriate or futile]

3. If neither of the above statements adequately expresses your wishes concerning artificially provided fluids and nutrition or CPR, please explain your wishes below.

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

D) ADDITIONAL INSTRUCTIONS: (You should provide any additional information about your health care preferences which is important to you and which may help those concerned with your care to implement your wishes. You may wish to direct your family members or your health care providers to consult with others, or you may wish to direct that your care be provided by a particular physician, hospital, nursing home, or at home. If you are or believe you may become pregnant, you may wish to state specific instructions. If you need more space than is provided here you may attach an additional statement to this directive.)

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

E) BRAIN DEATH: (The State of New Jersey recognizes the irreversible cessation of all functions of the entire brain, including the brain stem (also known as whole brain death), as a legal standard for the declaration of death. However, individuals who cannot accept this standard because of their personal religious beliefs may request that it not be applied in determining their death.)

Initial the following statement only if it applies to you:

_____ To declare my death on the basis of the whole brain death standard would violate my personal religious beliefs. I therefore wish my death to be declared solely on the basis of the traditional criteria of irreversible cessation of cardiopulmonary (heartbeat and breathing) function.
F) AFTER DEATH - ANATOMICAL GIFTS: (It is now possible to transplant human organs and tissue in order to save and improve the lives of others. Organs, tissues and other body parts are also used for therapy, medical research and education. This section allows you to indicate your desire to make an anatomical gift and if so, to provide instructions for any limitations or special uses.)

Initial the statements which express your wishes:

1. _____ I wish to make the following anatomical gift to take effect upon my death:
   
   A. _____ any needed organs or body parts
   
   B. _____ only the following organs or parts

   ____________________________________________ for the purposes of transplantation, therapy, medical research or education, or

   C. _____ my body for anatomical study, if needed.
   
   D. _____ special limitations, if any:

   ____________________________________________

If you wish to provide additional instructions, such as indicating your preference that your organs be given to a specific person or institution, or be used for a specific purpose, please do so in the space provided below.

___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

2. _____ I do not wish to make an anatomical gift upon my death.

Part Two: Signature and Witnesses

G) COPIES: The original or a copy of this document has been given to the following people (NOTE: It is important that you provide a family member, friend or your physician with a copy of your directive.):

1. name ________________________________  2. name ________________________________
   address ______________________________
   city __________________________ state _____
   telephone ___________________________

   address ______________________________
   city __________________________ state _____
   telephone ___________________________
H) SIGNATURE: By writing this advance directive, I inform those who may become entrusted with my health care of my wishes and intend to ease the burdens of decision making which this responsibility may impose. I understand the purpose and effect of this document and sign it knowingly, voluntarily and after careful deliberation.

Signed this __________ day of __________, 20_____.

signature ________________________________

address ________________________________

city __________________________ state ______

I) WITNESSES: 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, that he or she is personally known to me and that he or she appears to be of sound mind and free of duress or undue influence. I am 18 years of age or older, and am not designated by this or any other document as the person’s health care representative nor as an alternate health care representative.

1. witness ________________________________

address ________________________________

city __________________________ state ______

signature ________________________________

date ________________________________

2. witness ________________________________

address ________________________________

city __________________________ state ______

signature ________________________________

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

Follow these orders, then contact physician/APN. 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.

<table>
<thead>
<tr>
<th>A</th>
<th>GOALS OF CARE</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>(See reverse for instructions. This section does not constitute a medical order.)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>B</th>
<th>MEDICAL INTERVENTIONS: Person is breathing and/or has a pulse</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>- Transfer to hospital for medical interventions.</td>
</tr>
<tr>
<td></td>
<td>- Transfer to hospital only if comfort needs cannot be met in current location.</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>Additional Orders:_______________________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C</th>
<th>ARTIFICIALLY ADMINISTERED FLUIDS AND NUTRITION:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Always offer food/fluids by mouth if feasible and desired.</td>
</tr>
<tr>
<td></td>
<td>- No artificial nutrition.</td>
</tr>
<tr>
<td></td>
<td>- Defined trial period of artificial nutrition.</td>
</tr>
<tr>
<td></td>
<td>- Long-term artificial nutrition.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D</th>
<th>CARDIOPULMONARY RESUSCITATION (CPR)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Person has no pulse and/or is not breathing</td>
</tr>
<tr>
<td></td>
<td>- Attempt resuscitation/CPR</td>
</tr>
<tr>
<td></td>
<td>- Do not attempt resuscitation/DNAR</td>
</tr>
<tr>
<td></td>
<td>- Allow Natural Death</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E</th>
<th>AIRWAY MANAGEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Person is in respiratory distress with a pulse</td>
</tr>
<tr>
<td></td>
<td>- Intubate/use artificial ventilation as needed</td>
</tr>
<tr>
<td></td>
<td>- Do not intubate - Use O2, manual treatment to relieve airway obstruction, medications for comfort.</td>
</tr>
<tr>
<td></td>
<td>- Additional Order (for example defined trial period of mechanical ventilation) ___________________________</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>F</th>
<th>SIGNATURES:</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>I have discussed this information with my physician/APN.</td>
</tr>
<tr>
<td></td>
<td>Print Name________________________________________</td>
</tr>
<tr>
<td></td>
<td>Signature_________________________________________</td>
</tr>
<tr>
<td></td>
<td>- Person Named Above</td>
</tr>
<tr>
<td></td>
<td>- Health Care Representative/Legal Guardian</td>
</tr>
<tr>
<td></td>
<td>- Spouse/Civil Union Partner</td>
</tr>
<tr>
<td></td>
<td>- Parent of Minor</td>
</tr>
<tr>
<td></td>
<td>- Other Surrogate</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th></th>
<th>PRINT - Physician/APN Name</th>
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<tbody>
<tr>
<td></td>
<td>Phone Number</td>
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</table>

<table>
<thead>
<tr>
<th></th>
<th>Physician/APN Signature (Mandatory)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Date/Time</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Professional License Number</th>
</tr>
</thead>
</table>

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED

6/15/15
DIRECTIONS FOR HEALTH CARE PROFESSIONAL

COMPLETING POLST
- Must be completed by a physician or advance practice nurse.
- 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 designated 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 may request to modify the orders based on the known desires of the person or, if unknown, the person’s best interest.
- 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 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
- Eating, driving, gardening, enjoying grandchildren

Medical providers are encouraged to share information regarding prognosis in order for 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 named in this section by the person.

SECTION F
POLST must be signed by a practitioner, meaning a physician or APN, to be valid. Verbal orders are acceptable with follow-up signature by physician/ APN 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.
I understand that as a competent adult, I have the right to make decisions about my health care. There may come a time when I am unable, due to physical or mental incapacity, to make my own health care decision. In these circumstances, those caring for me will need direction and they will turn to someone who knows my values and health care wishes. By writing this durable power of attorney for health care I appoint a health care representative with the legal authority to make health care decisions on my behalf and to consult with my physician and others. I direct that this document become part of my permanent medical records.

A) CHOOSING A HEALTH CARE REPRESENTATIVE:

I, ______________________________, hereby designate _________________________________________, of _________________________________________________________________________________________
___________________________________________________________________________________________,
(home address and telephone number of health care representative)

as 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 measures. I direct my 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, my representative is authorized to make decisions in my best interest, based on what is known of my wishes.

This durable power of attorney for health care shall take effect in the event I become unable to make my own health care decisions, as determined by the physician who has primary responsibility for my care, and any necessary confirming determinations.

B) ALTERNATE REPRESENTATIVES: 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(s) to act as my health care representative, in the order of priority stated:

1. name ______________________________ address ______________________________
   city __________________________ state ________ telephone ______________________________
2. name ______________________________ address ______________________________
   city __________________________ state ________ telephone ______________________________

C) SPECIFIC DIRECTIONS: Please initial the statement below which best expresses your wishes.

_____ My health care representative is authorized to direct that artificially provided fluids and nutrition, such as by feeding tube or intravenous 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.
(If you have any additional specific instructions concerning your care you may use the space below or attach an additional statement.)

___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

D) COPIES: The original or a copy of this document has been given to my health care representative and to the following:

1. name ____________________________
   address ____________________________
   city __________________ state ______  telephone ____________________________

2. name ____________________________
   address ____________________________
   city __________________ state ______  telephone ____________________________

E) SIGNATURE: By writing this durable power of attorney for health care, I inform those who may become entrusted with my care of my health care wishes and intend to ease the burdens of decision making which this responsibility may impose. I have discussed the terms of this designation with my health care representative and he or she has willingly agreed to accept the responsibility for acting on my behalf in accordance with my wishes as expressed in this document. I understand the purpose and effect of this document and sign it knowingly, voluntarily and after careful deliberation.

Signed this __________ day of ____________, 20______.

signature ____________________________

address ____________________________

city __________________ state ______

F) WITNESSES: 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, that he or she is personally known to me, and that he or she appears to be of sound mind and free of duress or undue influence. I am 18 years of age or older, and am not designated by this or any other document as the person’s health care representative, nor as an alternate health care representative.

1. witness ____________________________ 2. witness ____________________________
   address ____________________________ address ____________________________
   city __________________ state ______  city __________________ state ______
   signature ____________________________ signature ____________________________
   date ____________________________ date ____________________________