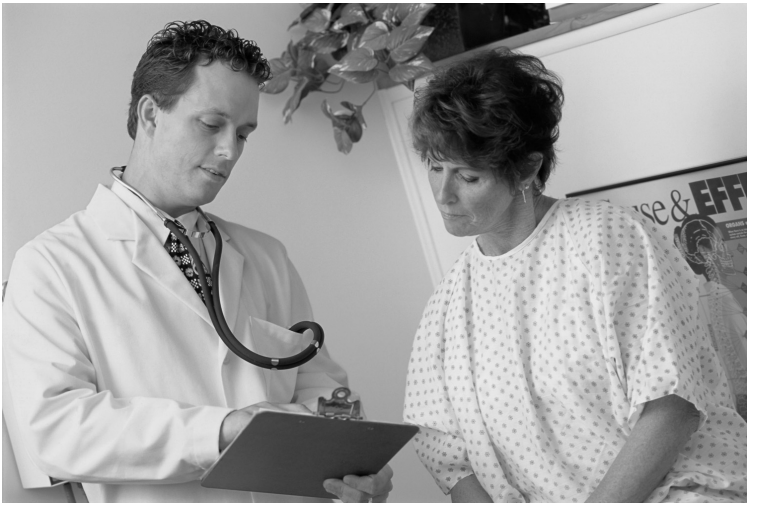
It's Your Decision



How to Make an Advance Health Care Directive

What Is An Advance Health Care Directive (Directive)?

A Directive is a written statement of your health care wishes. It is used in the event of an illness or injury that leaves you unable to communicate your health care wishes to others. Your Directive will not be used during any times when you can communicate your health care wishes to others.

Who Can Make A Directive?

You can make a Directive if you are 16 years of age or over. If you are under 16, special rules will apply.

Who Should Make A Directive?

Anyone who wishes to provide clear instructions or set out general principles about their health care treatment and/or who wishes to designate a Substitute Decision Maker should make a Directive.

Why Should I Make A Directive?

Directives allow you to accomplish two main goals:

1 Provide instructions and/or general principles about your health care that you want to be followed. These instructions and principles must be respected by your health care professionals (such as a doctor or nurse) and family members.

2 Appoint a Substitute Decision Maker who will act on your behalf in the event that you are not able to make your own health care decisions.

Directives provide clarity about your health care wishes and assist in preventing conflicts over deciding what treatments you should receive.

When Should I Make A Directive?

There are no time requirements for making a Directive. You should make a Directive when you feel comfortable with discussing your health care wishes and want to provide instructions about your health care treatment and/or when you want to appoint a substitute decision maker who will make health care decisions on your behalf if you are unable to do so.

How Should I Make A Directive?

All Directives must include the two following basic requirements:

1. **Your signature:**
   - If you are unable to sign, someone else may do so for you. They must sign in your presence and at your direction.
   - This person cannot be your appointed substitute decision maker or your appointed substitute decision maker's spouse (wife or husband).

2. **The signatures of at least two witnesses:**
   - At least two people must witness your signature. The witnesses cannot be your appointed substitute decision maker or your appointed substitute decision maker's spouse.

Directives can include one or both of the following sets of instructions:

1. **A written statement of your health care wishes/ instructions:**
   - You can include specific instructions and/or general principles about your health care treatment wishes. These can be as simple or as detailed as you choose. For example, if you cannot live independently and there is no hope of your recovery, you can state whether or not you wish to be kept alive by machines and/or medical treatments.

- If you give detailed instructions about specific illnesses and/or treatments, ensure that you are well informed about the illnesses and understand the risks and benefits of the treatments.

- Consult your health care professional if you have any questions about your health care treatment wishes and options.

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2. A substitute decision maker:

- A substitute decision maker is a person who will communicate your health care decisions if you are unable to do so. This person must be 19 years of age or over.

- Your substitute decision maker must indicate his or her acceptance of the appointment in writing.

- Your substitute decision maker should be someone who knows you well and that you trust. You should talk about your health care wishes with this individual.

- Your substitute decision maker will follow your written instructions. If your instructions are not clear or complete or if you have not provided any instructions, your substitute decision maker will follow your wishes if you have expressed them to him or her. If the substitute decision maker does not know your wishes, he or she will act according to what he or she believes to be in your best interests.

- You can appoint more than one substitute decision maker. If you appoint more than one, the first person named in your Directive will be appointed to act.

- If the first person is not available or is unable or unwilling to act, then the next person named will be appointed to act.

- If you appoint multiple substitute decision makers and want them to act jointly (as opposed to successively), you must indicate this in your Directive.

- If you do not appoint a substitute decision maker, one will be appointed for you from a list in the *Advance Health Care Directives Act.* Generally, this person will be a family member or a close relative.

- You can also indicate who you do not want to act as a substitute decision maker.

What Happens In Case Of A Medical Emergency?

In a medical emergency, a health care professional does not have to search for your Directive before giving treatment. However, if a health care professional is made aware of your Directive when you enter the emergency room, then your Directive must be followed.

Where Should I Keep My Directive?

A copy of your Directive should be given to your substitute decision maker(s), your doctor and close family members. At all times, you should keep with you a piece of paper saying where your Directive is located (see sample on back cover). Once you have been admitted into a hospital or other health care facility, your Directive should become part of your medical record.

How Can I Change My Directive?

It is very important to look over your Directive at least once a year or whenever your health care wishes change. You can change your Directive by doing one of three things:

1. Tearing up your Directive;
2. Making a new Directive or
3. Making a written statement that you want to change your first Directive. This must be signed and witnessed in the same way as a Directive.

Is My Directive Valid In Other Canadian Provinces?

It will be valid only if it meets the legal requirements of the province you are in when you need medical treatment.

Is My Directive Valid Outside Canada?

It will be valid only if it meets the legal requirements of the country you are in when you need medical treatment.

What Happens If I Do Not Make A Directive?

If you do not make a Directive and you become unable to communicate your health care wishes to others, a substitute decision maker will be appointed for you from a list in the *Advance Health Care Directives Act.*

For additional information and services contact your Regional Health Authority.

Additional copies may be downloaded at:
http://justice.gov.nl.ca/justice/publications/index.htm and
http://health.gov.nl.ca/health/publications/index.htm

ADVANCE HEALTH CARE DIRECTIVE

(TO BE PLACED ON MY MEDICAL RECORD)

I have stated my treatment wishes in this directive. If I am ever unable to communicate these wishes because of illness or injury, this directive must be used. If I am able to communicate my treatment wishes, this directive must not be used.

I, _____ *(your name),* of _____

(address/city/province), on this __ *(day)* of _____ *(month)*, _____ *(year)*, willingly and after careful deliberation, make this advance health care directive.

Signature: _____

(If you cannot sign with your signature, you can sign with a mark other than your signature, or you can direct someone other than your substitute decision maker(s) or your substitute decision maker's spouse to sign for you in your presence.)

We, the witnesses for this directive, are <u>not</u> the appointed substitute decision maker(s) or a spouse of the appointed substitute decision maker(s). We witness this directive in presence of _____ *(the maker of the directive)*.

Name: _____

Address:_____

Tel. #(Home): _____

Tel. # (Work): _____

Signature:_____

Name: _____

Address: _____

Tel. #(Home): _____

Tel.# (Work): _____

Signature: _____

<u>In this directive, I have set out the following</u> *<u>(you may choose one or both options)</u>***<u>:</u>**

☐ **The instructions and/or general principles I want to be followed about my health care treatment if I am ever unable to communicate these wishes because of illness, injury, or otherwise.** *(If you choose this option, please complete the "Instructions and/or General Principles about my Health Care Treatment" section below)*

☐ **The person(s) that I appoint to act as my substitute decision maker(s) if I am unable to communicate my health care wishes because of illness, injury, or otherwise and/or the person(s) that I do <u>not</u> wish to act as my substitute decision maker(s).** *(If you choose this option, please complete the "Substitute Decision Maker(s)" section below)*

Instructions and/or General Principles about my Health Care Treatment

These are the instructions and/or general principles that I want to be followed if I am unable to communicate a health care decision:

_____

_____

_____

_____

Appointment of Substitute Decision Maker(s)

You may appoint one or more substitute decision maker(s). If you require additional space, please attach another page.

I appoint the following individual(s) to act as my Substitute Decision Maker(s) to make health care decisions on my behalf in the event that I am unable to do so: *Each person that you appoint must indicate in writing that they accept the appointment*

1. Name: _____

Address: _____

Relationship to me: _____

Telephone # (Home/Cell): _____

Telephone # (Work): _____

Acceptance of Substitute Decision Maker #1

I, _____ *accept my appointment as Substitute Decision Maker. I am at least 19 years of age*.

Signature: _____

2. Name: _____

Address_____

Relationship to me: _____

Telephone # (Home/Cell): _____

Telephone # (Work): _____

Acceptance of Substitute Decision Maker #2

I, _____ *accept my appointment as Substitute Decision Maker. I am at least 19 years of age*.

Signature: _____

3. Name: _____

Address: _____

Relationship to me: _____

Telephone # (Home/Cell): _____

Telephone # (Work): _____

Acceptance of Substitute Decision Maker #3

I, _____ *accept my appointment as Substitute Decision Maker. I am at least 19 years of age*.

Signature: _____

4. Name: _____

Address_____

Relationship to me: _____

Telephone # (Home/Cell): _____

Telephone # (Work): _____

Acceptance of Substitute Decision Maker #4

I, _____ *accept my appointment as Substitute Decision Maker. I am at least 19 years of age*.

Signature: _____

If you have appointed <u>more than one</u> Substitute Decision Maker, please select <u>one</u> of the following:

☐ I want my Substitute Decision Makers to act <u>jointly</u>. If I have appointed only two Substitute Decision Makers, this means that their decisions must be unanimous. If I have appointed more than two, the decisions of the majority will be considered the decisions of all.

☐ I want my Substitute Decision Makers to act <u>successively</u>. This means that the person I have appointed first in the list will be the only person that will act as my Substitute Decision Maker. If that person is not available or is unable or unwilling to act, then the person I have designated second will be the only person that will act as my Substitute Decision Maker (and so on).

☐ I want my Substitute Decision Makers to act as follows: *(Complete if you wish your substitute decision makers to make decisions in different way from what is in the above two options)*

_____

_____

_____

I do not wish the following person(s) to be my substitute decision maker(s): *If you do not appoint a substitute decision maker, or if the person(s) appoint is/are not available or unable or unwilling to act, a substitute decision maker will be appointed for you under section 10 of the* Advance Health Care Directives Act. *If you require additional space, please attach another page.*

1. _____ 2. _____

I authorize my substitute decision maker(s) to give consent on my behalf for the following procedures/treatments: *The* Advance Health Care Directives Act *states that the consent by a substitute decision maker for the following procedures/treatments <u>has no effect unless you expressly authorize</u> the substitute decision maker to give such consent.*

1. Medical treatment for the primary purpose of research:

   ☐ Yes ☐ No

2. Sterilization that is not medically necessary for the protection of my health:

   ☐ Yes ☐ No

3. The removal of tissue from my body while I am living for transplantation to another person:

   ☐ Yes ☐ No

4. The removal of tissue from my body while I am living for the purpose of medical education or medical research:

   ☐ Yes ☐ No

I _____, have made an Advance Health Care Directive. A copy is located at the following place(s):

_____

_____

_____

_____

_____ _____

Your signature Date

Newfoundland Labrador

Department of Health and Community Services and
Department of Justice