CAPE REGIONAL
MEDICAL CENTER

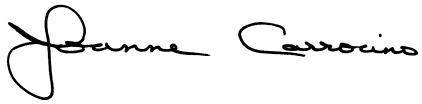
Dear Patient,

We are pleased to provide you with the attached "Advance Directive" (living will) information. An Advance Directive is a document that allows you to direct someone to make health care decisions for you and to state your wishes for medical treatment if you become unable to decide for yourself in the future. Your Advance Directive may be used to accept or refuse any procedure or treatment, including life-sustaining treatment. Also included is a summary of your rights to make decisions about your own health care under New Jersey Law published by the State Department of Health. These materials are intended to help you complete a document which accurately reflects your wishes.

You are eligible to fill out an Advance Directive in New Jersey if you are 18 years or older and are able to make your own decisions. You do not need an attorney or physician to complete a Directive although you may consult one if you wish. You do not need to have the Directive notarized. After completing the form, a copy should be included in your medical record at any hospital you use. Please be sure to keep the original for future use and give copies to those who are important to you, such as family members.

Please do not hesitate to contact the Social Work/Case Management Department at (609) 463-2160 if you have any questions or need assistance in completing the Advance Directive.

Sincerely,



Joanne Carrocino, FACHE
President and CEO
Cape Regional Medical Center

JC/jay

NEW JERSEY DEPARTMENT OF HEALTH

YOUR RIGHT TO MAKE HEALTH CARE DECISIONS

This document explains your rights to make decisions about your own health care under New Jersey law. It also tells you how to plan ahead for your health care if you become unable to decide for yourself because of an illness or accident. It contains a general statement of your rights and some common questions and answers.

Your Basic Rights

You have the right to receive an understandable explanation from your doctor of your complete medical condition, expected results, benefits and risks of the treatment recommended by our doctor, and reasonable medical alternatives. You have the right to accept or refuse any procedure or treatment used to diagnose or treat your physical or mental condition, including life-sustaining treatment.

You also have the right to control decisions about your health care in the event you become unable to make your own decisions in the future by completing an advance directive.

What happens if I'm unable to decide about my health care?

If you become unable to make treatment decisions, due to illness or an accident, those caring for you will need to know about your values and wishes in making decisions on your behalf. That's why it's important to write an advance directive.

What is an advance directive?

An advance directive is a document that allows you to direct who will make health care decisions for you and to state your wishes for medical treatment if you become unable to decide for yourself in the future. Your advance directive may be used to accept or refuse any procedure or treatment, including life-sustaining treatment.

What types of advance directives can I use?

There are three kinds of advance directives that you can use to say what you want and who you want your doctors to listen to:

A ***PROXY DIRECTIVE*** (also called a "durable power of attorney for health care") lets you name a "health care representative", such as a family member or friend, to make health care decisions on your behalf.

An ***INSTRUCTION DIRECTIVE*** (also called a "living will") lets you state what kinds of medical treatments you would accept or reject in certain situations.

A ***COMBINED DIRECTIVE*** lets you do both. It lets you name a health care representative and tells that person your treatment wishes.

Who can fill out these forms?

You can fill out an advance directive in New Jersey if you are 18 years or older and you are able to make your own decisions. You do not need a lawyer to fill it out.

Who should I talk to about advance directives?
You should talk to your doctor, family members, close friends, or others you trust to help you. Your doctor or a member of our staff can give you more information about how to fill out an advance directive.

What should I do with my advance directive?
You should talk to your doctor about it and give a copy to him or her. You should also give a copy to your health care representative, family member(s), or others close to you. Bring a copy with you when you must receive care from a hospital, nursing home, or other health care agency. Your advance directive becomes part of your medical records.

What if I don't have an advance directive?
If you become unable to make treatment decisions and you do not have an advance directive, your close family members will talk to your doctor and in most cases, may then make decisions on your behalf. However, if your family members, doctor, or other caregivers disagree about your medical care, if may be necessary for a court to appoint someone as your legal guardian. (This also may be needed if you do not have a family member to make decisions on your behalf.) That's why it's important to put your wishes in writing to make it clear who should decide for you and to help your family and doctor know what you want.

Will my advance directive be followed?
Yes. Everyone responsible for your care must respect your wishes that you have stated in your advance directive. However, if your doctor, nurse, or other professional has a sincere objection to respecting your wishes to refuse life-sustaining treatment, he or she may have your care transferred to another professional who will carry them out.

What if I change my mind?
You can change or revoke any of these documents at a later time.

Will I still be treated if I don't fill out an advance directive?
Yes. You don't have to fill out any forms if you don't want to and you will still get medical treatment. Your insurance company also cannot deny coverage based on whether or not you have an advance directive.

What other information and resources are available to me?
Your doctor or a member of our staff can provide you with more information about our policies on advance directives. You also may ask for written informational materials and help . If there is a question or disagreement about your health care wishes, we have an ethics committee or other individuals who can help.

December 1991 – Hospitals and Home Health Agencies

CHECKLIST
QUESTIONS TO ASK YOURSELF

Thinking About Your Health Care Wishes

A. Why am I writing an advance directive?
B. What are my treatment wishes?
   1. in situations near the end of life?
   2. in situations of serious injury or illness?

Talking With Others

A. Physicians and other health care professionals
   1. do I understand the medical terminology?
   2. do they understand my wishes?

Selecting a Health Care Representative

A. Am I confident that my designated representative understands my personal values and health care wishes?
A. Does my health care representative understand his or her responsibilities?
B. Has he or she clearly agreed to serve as my representative and to communicate my wishes to my doctor and other concerned with my care?
C. Have I selected an alternative health care representative?

My Instructions

Have I clearly stated my instructions and included other relevant information about my treatment wishes regarding:
the provision – withholding or withdrawal of specific treatment?

A. artificially provided fluids and nutrition?
B. the medical conditions in which I want my wishes implemented?
C. special considerations I may have concerning my care and treatment?

Witness

Have I had my directive properly witnessed?

Distribution of My Advance Directive

Have I given a copy of my directive to those who should have one such as:

A. my health care representative?
B. my physician or other health care provider?
C. the hosptial or nursing home which I am about to enter?
D. family members, friends, alternate representatives and my religious advisor?

Periodic Review

Have I made a note to review my directive on a regular basis in the future?

I HAVE AN ADVANCE DIRECTIVE FOR HEALTH CARE

Name_____

Address_____

City_____**State**_____

For information please contact as soon as possible:

Name_____

Address_____

City_____**State**_____

Or

Name_____

Address_____

City_____**State**_____

(cut along lines to place in wallet)

In the hope that I may help others, I hereby make this anatomical gift to take effect upon my death. The words and marks below indicate my desires.

I give _____ any needed organs or parts

Or _____ only the following organs

or parts_____**.**

(for the purposes of transplantation, therapy, medical research or education)

Signed by the donor and the following two witnesses in the presence of each other.

Date of birth

Signature of donor_____

Date signed_____

City & State_____

Witness_____

Witness_____

(This is a legal document: under the Uniform Anatomical Gift Act)

(cut along lines to place in wallet)

ADVANCE DIRECTIVE FOR HEALTH CARE
(LIVING WILL)

This Advance Directive is one of many forms of Advance Directives which are available, others are equally valid. Completion of an Advance Directive is voluntary. Your medical care is not contingent upon your completion of an Advance Directive. Please consider whatever Advance Directive you may choose carefully. It is important that each person completing an Advance Directive be fully informed as to its meaning and implications.

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

A. *I _____, being of sound mind, hereby make known my instructions for future health care in the event that for reasons due to physical or mental incapacity, I am unable to participate in decisions regarding my care.*

B. *Please initial the Statements with which you agree:*
(Select #1 or #2, but not both) (select #3 if you agree)

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

2._____ No Life Sustaining measures to prolong my life if:
(1) Treatment is futile or (2) I am permanently unconscious or (3) I am suffering From a terminal condition or (4) I have an irreversible illness or condition.

3._____ I direct that I be given appropriate medical care and medication to alleviate pain and suffering even though this may hasten my death.

C. *Additional Comments or Instructions:*

_____

_____

D. *Designation of a Health Care Representative:*
I hereby designate:

_____
Name Relationship

_____
Street

_____
City State Telephone

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 interests, based upon what is known of my wishes.

E. Alternative Representative:

If the person I have designated above is unable to act as my Health Care Representative:

1. _____
Name Relationship

_____
Street

_____
City State Telephone

2. _____
Name Relationship

_____
Street

_____
City State Telephone

F. I have discussed my wishes with these persons and trust their judgement on my behalf. I understand the purpose and effect of this document, and I sign it knowingly, voluntarily and after careful deliberation.

_____
Signature Date

_____
Street City State

_____
Date of Birth Social Security

G. Witnesses: (cannot be Representatives listed in D or E)

I declare that the person who signed this document did so in my presence, and that he or she understands the significance of this document.

_____
Witness Date

_____
Address

_____
Witness Date

_____
Address