

**LAW OFFICE OF FRANK M. WILLIAMS, L.L.C.**  
**COMBINED ADVANCED DIRECTIVE FOR HEALTH CARE/LIVING WILL**  
**QUESTIONNAIRE**

*NOTE: THIS FORM IS NOT TO BE USED AS A COMBINED ADVANCE DIRECTIVE FOR HEALTH CARE IN NEW JERSEY AS THIS FORM DOES NOT CONFORM TO THE NEW JERSEY STATUTES. THIS IS TO BE USED FOR INFORMATIONAL PURPOSES ONLY.*

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Instructions:** Please answer all six (6) parts and return to the office at your earliest convenience.

**I. 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, please initial each of the following statements (a, b, c) with which you agree (NOTE: MOST CLIENTS SELECT ALL THREE):**

- 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.

“To me, terminal condition means that my physicians have determined that...”

Circle the applicable phrase:

Option 1: I will die within a few days.

Option 2: I will die within a few weeks.

Option 3: I have a life expectancy of approximately \_\_\_\_\_ month(s) or less.

(Enter number of months not to exceed 6 months as in accordance with the New Jersey Advanced Directives for Health Care Act, N.J.S.A. 26:2H-53, et seq.)

b. { } If there should come a time when I become 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 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 to provide additional instructions.}

Examples of conditions which I find unacceptable are: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**II. SPECIFIC INSTRUCTIONS:** Artificially Provided Fluids and Nutrition; Cardiopulmonary Resuscitation (CPR). On the prior page(s) 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, select the bracketed phrase with which you agree:

1. In the circumstances I initialed in Section I(2) of this document, 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. (MOST SELECT THIS)

OR

be provided to the extent medically appropriate.

2. In the circumstances I initialed in Section I(2) of this document, if I should suffer a cardiac arrest, I also direct that cardiopulmonary resuscitation (CPR),

not be provided and that I be allowed to die. (MOST SELECT THIS)

OR

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. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**III. 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 health care representative, 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.)

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**IV. 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.**)

Check 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.

**V. 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.) Please select the statement(s) below which express your wishes.

1.  I do not wish to make an anatomical gift upon my death.
2.  I wish to make the following anatomical gift to take effect upon my death:

any and ALL needed organs or body parts;

any vital organs or body parts;

OR

only the following organs or parts: \_\_\_\_\_  
\_\_\_\_\_

for the purpose(s) of:

transplantation,

therapy,

medical research,

education,

anatomical study

Special Instructions and/or Limitations: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**VI. BURIAL/CREMATION.** N.J.S.A. 45:37-22 provides for the appointment of a Funeral Agent to oversee your affairs, which we will incorporate in your Last Will and Testament. Although your Last Will and Testament will include the controlling language for the appointment of your Funeral Agent, we commonly make reference in your Combined Advanced Directive for Health Care/Living Will to your final wishes. Please initial the statement below which expresses your wishes:

- 1.  Upon my death, I direct that my body be cremated.

If you wish to provide additional instructions, such as indicating your preference for your funeral or final resting place of your cremains, please do so in the space provided below (i.e., length/duration of viewing/service, possession of cremains, church, burial, etc.).

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- 2.  Upon my death, I direct that my body shall be buried.

If you wish to provide additional instructions, such as indicating your preference for your funeral or final resting place of your burial, please do so in the space provided below (i.e., length/duration of viewing/service, church, cemetery, etc.).

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