

IT'S YOUR LIFE. IT'S YOUR CHOICE.



NORTHWEST TERRITORIES

Personal Directive

A.NOTES

A1 “Personal Directive” = Advance Directive

A2 To complete a Personal Directive, you (the “Director”) must:

- Be **19** years of age or older
- Be mentally capable

A3 “Agent” = Substitute Decision-Maker

A4 An Agent must:

- Be **19** years of age or older
- Be mentally capable
- Agree to be your Agent
- Sign the Personal Directive in the presence of a witness

A5 You must sign your Personal Directive in the presence of a witness.

A6 If you cannot complete and sign this Personal Directive yourself, you may ask someone else to sign it for you. This must be done in your presence and the presence of a witness. This person cannot be your Agent, nor their spouse.

A7 The witness must:

- Be **19** years of age or older
- **NOT** be your spouse
- **NOT** be the same person you chose as your Agent, nor their spouse
- **NOT** be the person who signed on your behalf, nor their spouse
- Sign the Personal Directive in your presence

A8 Personal decisions (Section C) can be about any or all personal matters that are non-financial, including medical treatments, living arrangements, and personal activities, such as recreation, employment, or education.

A9 If you feel you have special circumstances that the Dying With Dignity Canada forms do not address, we suggest that you consult with a lawyer.



B. PERSONAL INFORMATION

- B1 I, _____^(NAME) revoke (cancel) any previous Personal Directives made by me.
- B2 Legal first name: _____
- B3 Legal last name: _____
- B4 Preferred name (If different from legal name): _____
- B5 Pronouns (Optional): _____
- B6 Date of birth: _____
- B7 Address: _____
- B8 Phone: _____
- B9 Email: _____

C. APPOINTING AN AGENT (RECOMMENDED, BUT OPTIONAL)

- C1 I appoint (choose) the following people to make health care and other personal decisions for me if I am no longer capable of making health care decisions for myself:

AGENT #1

- C2 First name: _____
- C3 Last name: _____
- C4 Relationship to me: _____
- C5 Address: _____
- C6 Phone: _____
- C7 Email: _____



AGENT #2 (OPTIONAL)

C8 First name: _____

C9 Last name: _____

C10 Relationship to me: _____

C11 Address: _____

C12 Phone: _____

C13 Email: _____

NOTE: Only complete the next section if you choose more than one Agent.

C14 I want my Agents to act:

_____ **Jointly** (They need to make decisions together)
(INITIAL)

_____ **Consecutively** (The second Agent will only make decisions if the first
(INITIAL) is unavailable)



D. HEALTH CARE DIRECTIONS

(PLEASE READ EACH LINE CAREFULLY)

D1 _____ If I am sedated and unable to communicate, I would like the sedation
(INITIAL) lifted so that I can decide for myself to accept or refuse a particular therapy.

D2 Initial only **ONE** of the following two options. If you choose Option 1, skip to page 6.

_____ **Option 1:** I direct that my life be prolonged, and that I be provided
(INITIAL) all **life-sustaining treatments** that apply to my medical condition.

OR

_____ **Option 2:** I direct that I **only receive care that will keep me comfortable and**
(INITIAL) **pain free**, and that my life is not prolonged (initial the options that apply below).

_____ **In any circumstance**
(INITIAL)

_____ **If I experience a serious life-threatening illness that cannot be reversed**
(INITIAL)

_____ **If I experience permanent, chronic, and debilitating suffering**
(INITIAL)

_____ **If I have advanced dementia** (please describe what this would look like for you)
(INITIAL)

_____ **OTHER** (please explain)
(INITIAL)

D3 I specifically **REFUSE** (say no to) the following (initial where you refuse):

(INITIAL) **Electrical, mechanical, or other artificial stimulation of my heart** (such as CPR)

(INITIAL) **Respirator or ventilator**

(INITIAL) **Artificial feeding such as through a stomach tube, or an intravenous line (IV)**

(INITIAL) **Being spoon fed, if I am no longer able to feed myself**

(INITIAL) **Artificial hydration (fluids) by intravenous line**

(INITIAL) **Antibiotics**

(INITIAL) **Transfer to an intensive care unit or similar facility**

D4 I would prefer to be cared for (select one):

(INITIAL) **At home**

(INITIAL) **In hospice**

(INITIAL) **In hospital**

D5 _____
(INITIAL) **If my health care provider will not follow this Personal Directive, I ask that my care be transferred to another health care provider who will respect my legal rights.**

D6 _____
(INITIAL) **If I should be a patient in a health care facility which will not follow this Personal Directive, I ask that I be transferred to another facility.**

ADDITIONAL DIRECTIONS:



E. SIGNATURES

MY SIGNATURE (THE “DIRECTOR”)

E1 First name: _____

E2 Last name: _____

E3 Signature: _____

E4 Date: _____

OR

SIGNATURE ON MY BEHALF (IN THE PRESENCE OF THE WITNESS BELOW)

E5 First name: _____

E6 Last name: _____

E7 Relationship to the “Director”: _____

E8 Signature: _____

E9 Address: _____

E10 Phone: _____

E11 Email: _____

E12 Date: _____



AGENT #1

I agree to be the Agent for the person who created this Personal Directive. I declare that I am eligible to be an Agent, that I am aware of and accept the instructions in this Personal Directive, and my duties as an Agent under the *Personal Directives Act*.

E13 First name: _____

E14 Last name: _____

E15 Signature: _____

E16 Date: _____

AGENT #2 (OPTIONAL)

I agree to be the Agent for the person who created this Personal Directive. I declare that I am eligible to be an Agent, that I am aware of and accept the instructions in this Personal Directive, and my duties as an Agent under the *Personal Directives Act*.

E17 First name: _____

E18 Last name: _____

E19 Signature: _____

E20 Date: _____

WITNESS

I certify that I witnessed the signing of this Personal Directive. I declare that I am not the spouse of the Director, the Agent nor the spouse of the Agent, or the person who signed on behalf of the Director, nor their spouse (if applicable).

E21 First name: _____

E22 Last name: _____

E23 Signature: _____

E24 Address: _____

E25 Phone: _____

E26 Email: _____

E27 Date: _____



F. DISTRIBUTION

I have shared this Personal Directive with the following people. This is a reminder to me to keep these people informed of any changes. I am aware that outdated copies of my Personal Directive may create confusion.

F1 Name: _____

F2 Name: _____

F3 Name: _____

F4 Name: _____

F5 Name: _____

F6 Name: _____

G. REVIEW

G1 You should review your Personal Directive:

- At least every three years
- When your health situation changes
- When your Agent(s) change(s)

(INITIAL) **Date of last review:** _____

(INITIAL) **Date of last review:** _____

(INITIAL) **Date of last review:** _____

(INITIAL) **Date of last review:** _____



H. NEXT STEPS

- H1 After completing your Personal Directive, re-read it to ensure your preferences are clear.** Then, review it with your Agent(s). If a health care provider does not know you, they may need a copy of the Personal Directive to understand your wishes for care.
- H2** Keep a copy of your Personal Directive in an easy-to-find place in an emergency. Leave a note in a prominent place, such as on your fridge with a magnet. This will let emergency personnel know where to look and who to call in a crisis. You can also print a wallet card and fridge note from the Dying With Dignity Canada website at dyingwithdignity.ca/advance-care-planning.
- H3 Do not store your Personal Directive in any locked box, drawer or safe.**
- H4** Discuss your completed Personal Directive with your health care provider. Give them a copy to put in your medical file. However, do not assume that doing so will result in your Personal Directive being available in an emergency. You or your Agent(s) must ensure health care providers are provided with a copy of your Personal Directive. That is why you should appoint an Agent.
- H5** If there are no changes to be made, sign the Personal Directive again with the new date.
- H6** Your medical condition may change. Or you may reconsider some of the directions you wrote down. Download a new Personal Directive at dyingwithdignity.ca/advance-care-planning or call Dying With Dignity Canada (DWDC) toll free at **1-800-495-6156** to receive a copy in the mail. Tell everyone involved in your care that you have updated your Personal Directive.

