NEW BRUNSWICK

Enduring Power of Attorney for Personal Care and Health Care Directive

A. NOTES

A1 **If you previously completed an "Advance Health Care Directive" that appointed a "health proxy" under the now repealed *Advance Health Care Directives Act* prior to July 1, 2020, it is considered to be an "Enduring Power of Attorney," which appoints a "Power of Attorney for Personal Care" – with authority regarding health care decisions and a Health Care Directive under the new legislation.**

A2 **"Enduring Power of Attorney for Personal Care" = Advance Directive**

A3 **You (the "Grantor") must:**

- Understand the information relevant to decisions and the reasonably foreseeable consequences of these decisions

A4 **"Attorney for Personal Care" = Substitute Decision-Maker**

A5 **An Attorney for Personal Care must:**

- Be **19** years of age or older
- **NOT** provide you with paid health care services or support services, unless they are your spouse, common-law partner or relative
- **NOT** be convicted of an offence involving dishonesty, unless you state that you are aware of the conviction
- Agree to be your Attorney for Personal Care

A6 **You must sign your Enduring Power of Attorney for Personal Care in the presence of TWO witnesses.**

A7 **If you cannot complete and sign this Enduring Power of Attorney for Personal Care, someone else can sign it for you. This must be done in your presence and the presence of TWO witnesses. This person must be 19 years of age or older. This person cannot be your Attorney for Personal Care or their spouse, common-law partner, or child.**

A8 **The witnesses must:**

- Be **19** years of age or older
- **NOT** be the same person you chose as your Attorney for Personal Care, nor their spouse, common-law partner or child
- Sign the Enduring Power of Attorney for Personal Care in your presence

A9 **IMPORTANT NOTICE: If you are an assisted, supported, or represented person under the *Supported Decision-Making and Representation Act*, be aware that appointing a decision-making supporter or representative for personal care may remove the authority granted to your Attorney for Personal Care granted in this Enduring Power of Attorney for Personal Care.**

A10 **Any changes made to the instructions in your Health Care Directive require you to revoke the existing Enduring Power of Attorney for Personal Care and create a new one.**

A11 **"Personal care" (Section C) includes any matter relating to the wellbeing of a person, including health care, diet, clothing, accommodation, support services, education, employment, recreation and social activities.**

A12 **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, ______________________________ revoke (cancel) any previous Enduring**
(NAME)
Powers of Attorney for Personal Care and/or Health Care Directive 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 ATTORNEY FOR PERSONAL CARE

(RECOMMENDED, BUT OPTIONAL)

C1 I appoint (choose) the following people to make personal care decisions for me if I do not have the capacity to do so for myself:

ATTORNEY FOR PERSONAL CARE #1

C2 **First name:** ______________________________

C3 **Last name:** ______________________________

C4 **Relationship to me:** ______________________________

C5 **Address:** ______________________________

C6 **Phone:** ______________________________

C7 **Email:** ______________________________

ATTORNEY FOR PERSONAL CARE #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 Attorney for Personal Care.

C14 **I want my Attorneys for Personal Care to act:**

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

__________ (INITIAL) **Consecutively** (The second Attorney for Personal Care will only make decisions if the first is unavailable)

C15 **I authorize my Attorney(s) of Personal Care to make medical decisions on my behalf when I lack the capacity to do so for myself:**

__________ (INITIAL) **With no restrictions**

__________ (INITIAL) **With the following restrictions** (please describe)

D. HEALTH CARE DIRECTIONS

(PLEASE READ EACH LINE CAREFULLY)

D1 ____________ (INITIAL) **If I am sedated and unable to communicate, I would like the sedation 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 7.**

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

OR

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

____________ (INITIAL) **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)

____

____

____

____

____

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 Enduring Power of Attorney for Personal Care, 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 Enduring Power of Attorney for Personal Care, I ask that I be transferred to another facility.**

ADDITIONAL DIRECTIONS:

____

____

____

____

____

____

MEDICAL ASSISTANCE IN DYING AND ADVANCE REQUESTS

D7 I understand that the current laws of Canada do not allow me to request medical assistance in dying (MAID) in advance. I understand that my Attorney for Personal Care cannot consent to MAID on my behalf. If the law changes, here are my directions regarding MAID. I wish for my Attorney for Personal Care and health care providers to act on my directions below.

E. SIGNATURES

MY SIGNATURE (THE “GRANTOR”)

E1 **First name:** ____________________

E2 **Last name:** ____________________

E3 **Signature:** ____________________

E4 **Date:** ____________________

OR

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

E5 **First name:** ____________________

E6 **Last name:** ____________________

E7 **Relationship to the “Grantor”:** ____________________

E8 **Signature:** ____________________

E9 **Address:** ____________________

E10 **Phone:** ____________________

E11 **Email:** ____________________

E12 **Date:** ____________________

ATTORNEY FOR PERSONAL CARE #1

I agree to be the Attorney for Personal Care for the person who created this Enduring Power of Attorney for Personal Care. I understand the responsibilities that come with this role.

E13 **First name:** ____________________

E14 **Last name:** ____________________

E15 **Signature:** ____________________

E16 **Date:** ____________________

ATTORNEY FOR PERSONAL CARE #2 (OPTIONAL)

I agree to be the Attorney for Personal Care for the person who created this Enduring Power of Attorney for Personal Care. I understand the responsibilities that come with this role.

E17 **First name:** ____________________

E18 **Last name:** ____________________

E19 **Signature:** ____________________

E20 **Date:** ____________________

WITNESS #1

I certify that I witnessed the signing of this Enduring Power of Attorney for Personal Care. I declare that I am not the Attorney for Personal Care nor the spouse, common-law partner or child of the Attorney for Personal Care.

E21 **First name:** ______________________________

E22 **Last name:** ______________________________

E23 **Signature:** ______________________________

E24 **Address:** ______________________________

E25 **Phone:** ______________________________

E26 **Email:** ______________________________

E27 **Date:** ______________________________

WITNESS #2

I certify that I witnessed the signing of this Enduring Power of Attorney for Personal Care. I declare that I am not the Attorney for Personal Care nor the spouse, common-law partner or child of the Attorney for Personal Care.

E28 **First name:** ______________________________

E29 **Last name:** ______________________________

E30 **Signature:** ______________________________

E31 **Address:** ______________________________

E32 **Phone:** ______________________________

E33 **Email:** ______________________________

E34 **Date:** ______________________________

F. DISTRIBUTION

I have shared this Enduring Power of Attorney for Personal Care 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 Enduring Power of Attorney for Personal Care may create confusion.

F1 **Name:** ______________________________

F2 **Name:** ______________________________

F3 **Name:** ______________________________

F4 **Name:** ______________________________

F5 **Name:** ______________________________

F6 **Name:** ______________________________

G. REVIEW

G1 **You should review your Enduring Power of Attorney for Personal Care and Health Care Directive:**

- At least every three years
- When your health situation changes
- When your Attorney(s) for Personal Care change(s)

__________ **Date of last review:** ______________________________
(INITIAL)

__________ **Date of last review:** ______________________________
(INITIAL)

__________ **Date of last review:** ______________________________
(INITIAL)

__________ **Date of last review:** ______________________________
(INITIAL)

H. NEXT STEPS

H1 **After completing your Enduring Power of Attorney for Personal Care and Health Care Directive, re-read it to ensure your preferences are clear.** Then, review it with your Attorney(s) for Personal Care. If a health care provider does not know you, they may need the Health Care Directive to understand your wishes for care.

H2 Keep a copy of your Enduring Power of Attorney for Personal Care and Health Care 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 Enduring Power of Attorney for Personal Care and Health Care Directive in any locked box, drawer or safe.**

H4 Discuss your completed Enduring Power of Attorney for Personal Care and Health Care 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 Enduring Power of Attorney for Personal Care and Health Care Directive being available in an emergency. You or your Attorney(s) for Personal Care must ensure health care providers are provided with a copy of your Enduring Power of Attorney for Personal Care and Health Care Directive. That is why you should appoint an Attorney for Personal Care.

H5 If there are no changes to be made, sign the Enduring Power of Attorney for Personal Care and Health Care Directive again with the new date.

H6 Your medical condition may change. Or you may reconsider some of the instructions you wrote down. Download a new Enduring Power of Attorney for Personal Care and Health Care 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 Enduring Power of Attorney for Personal Care and Health Care Directive.