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

DYING WITH DIGNITY CANADA

NEWFOUNDLAND AND LABRADOR

Advance Health Care Directive

A. NOTES

A1 **"Advance Health Care Directive" = Advance Directive**

A2 **To complete an Advance Health Care Directive, you (the "Maker") must:**

- Be **16** years of age or older
- Be competent

A3 **A Substitute Decision-Maker must:**

- Be **19** years of age or older
- Agree in writing to be your Substitute Decision-Maker

A4 **You must sign your Advance Health Care Directive in the presence of TWO witnesses.**

A5 **If you cannot complete and sign this Advance Health Care Directive yourself, someone else can sign it for you. This must be done in your presence and the presence of TWO witnesses. This person cannot be your Substitute Decision-Maker, nor their spouse.**

A6 **The witnesses must:**

- **NOT** be the same person you chose as your Substitute Decision-Maker, nor their spouse
- Sign the Advance Health Care Directive in your presence, and each other's presence

A7 **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 Advance Health Care Directives made by me.**
(NAME)

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 A SUBSTITUTE DECISION-MAKER
(RECOMMENDED, BUT OPTIONAL)

C1 I appoint (choose) the following people to make health care decisions for me if I lose competency to do so for myself:

SUBSTITUTE DECISION-MAKER #1

C2 **First name:** _____

C3 **Last name:** _____

C4 **Relationship to me:** _____

C5 **Address:** _____

C6 **Phone:** _____

C7 **Email:** _____

SUBSTITUTE DECISION-MAKER #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 Substitute Decision-Maker.

C14 **I want my Substitute Decision-Makers to act:**

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

_____ (INITIAL) **Consecutively** (The second Substitute Decision-Maker will only make decisions if the first is unavailable)

C15 I **DO NOT want the following person(s) to act as my Substitute Decision-Maker.**
If the person(s) you appoint as Substitute Decision-Maker(s) are unavailable or unwilling to act, a Substitute Decision-Maker will be appointed for you under section 10 of the ***Advance Health Care Directives Act***. Use this space to identify anyone you would not want to act in this capacity for you, including their full name and relationship to you.

_____

_____

_____

_____

_____

_____

_____

_____

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 6.**

_____ (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 Advance Health Care 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 Advance Health Care Directive, 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 Substitute Decision-Maker cannot consent to MAID on my behalf. If the law changes, here are my directions regarding MAID. I wish for my Substitute Decision-Maker and health care providers to act on my directions below.

E. SIGNATURES

MY SIGNATURE (THE "MAKER")

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 "Maker":** _____

E8 **Signature:** _____

E9 **Address:** _____

E10 **Phone:** _____

E11 **Email:** _____

E12 **Date:** _____

SUBSTITUTE DECISION-MAKER #1

I agree to be the Substitute Decision-Maker for the person who created this Advance Health Care Directive. I understand the responsibilities that come with this role. I certify that I am at least **19** years of age.

E13 **First name:** _____

E14 **Last name:** _____

E15 **Signature:** _____

E16 **Date:** _____

SUBSTITUTE DECISION-MAKER #2 (OPTIONAL)

I agree to be the Substitute Decision-Maker for the person who created this Advance Health Care Directive. I understand the responsibilities that come with this role. I certify that I am at least **19** years of age.

E17 **First name:** _____

E18 **Last name:** _____

E19 **Signature:** _____

E20 **Date:** _____

WITNESS #1

I certify that I witnessed the signing of this Advance Health Care Directive. I declare that I am not the Substitute Decision-Maker nor the spouse of the Substitute Decision-Maker.

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 Advance Health Care Directive. I declare that I am not the Substitute Decision-Maker nor the spouse of the Substitute Decision-Maker.

E28 **First name:** _____

E29 **Last name:** _____

E30 **Signature:** _____

E31 **Address:** _____

E32 **Phone:** _____

E33 **Email:** _____

E34 **Date:** _____

F. DISTRIBUTION

I have shared this Advance Health Care 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 Advance Health Care Directive may create confusion.

F1 **Name:** _____

F2 **Name:** _____

F3 **Name:** _____

F4 **Name:** _____

F5 **Name:** _____

F6 **Name:** _____

G. REVIEW

G1 You should review your Advance Health Care Directive:

- At least every three years
- When your health situation changes
- When your Substitute Decision-Maker(s) 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 Advance Health Care Directive, re-read it to ensure your preferences are clear.** Then, review it with your Substitute Decision-Maker(s). If a health care provider does not know you, they may need the Advance Health Care Directive to understand your wishes for care.

H2 Keep a copy of your Advance 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 Advance Health Care Directive in any locked box, drawer or safe.**

H4 Discuss your completed Advance 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 Advance Health Care Directive being available in an emergency. You or your Substitute Decision-Maker(s) must ensure health care providers are provided with a copy of your Advance Health Care Directive. That is why you should appoint a Substitute Decision-Maker.

H5 If there are no changes to be made, sign the Advance Health Care 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 Advance 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 Advance Health Care Directive.