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

DYING WITH DIGNITY CANADA

NOVA SCOTIA

Personal Directive

A. NOTES

A1 **"Personal Directive" = Advance Directive**

A2 **To make a Personal Directive, you (the "Maker") must:**

- Have capacity

A3 **"Delegate" = Substitute Decision-Maker**

A4 **A Delegate must:**

- Be **19** years of age or older
- Agree to be your Delegate
- **NOT** provide paid personal care services to you, unless they are your spouse or relative or you have specifically authorized them to do so in this Personal Directive

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

A6 **If you cannot complete and sign this Personal Directive yourself, someone else can sign it for you. This must be done in your presence and the presence of a witness. This person cannot be your Delegate, your Delegate's spouse, or a witness.**

A7 **The witnesses must:**

- **NOT** be the same person you chose as your Delegate, nor their spouse
- **NOT** be the person who signs on your behalf, nor their spouse
- Sign the Personal Directive in your presence

A8 **Personal care decisions (Section C) include those related to health care, nutrition, hydration, shelter, residence, clothing, hygiene, safety, comfort, recreation, social activities and support services.**

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,** _____ **revoke (cancel) any previous Personal 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 DELEGATE
(RECOMMENDED, BUT OPTIONAL)

C1 I appoint (choose) the following people to make personal care decisions for me if I am not capable of doing so for myself:

DELEGATE #1

C2 **First name:** _____

C3 **Last name:** _____

C4 **Relationship to me:** _____

C5 **Address:** _____

C6 **Phone:** _____

C7 **Email:** _____

DELEGATE #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 Delegate.

C14 **I want my Delegates to act:**

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

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

C15 **Initial only ONE of the following two options. If you choose Option 1, skip to section D.**

_____ (INITIAL) **Option 1:** I authorize my Delegate(s) to make personal decisions on my behalf for **all personal matters of a non-financial nature** that relate to me.

OR

_____ (INITIAL) **Option 2:** I authorize my Delegate(s) to make personal decisions on my behalf for the **following** personal matters of a non-financial nature that relate to me:

_____ (INITIAL) **Health care**

_____ (INITIAL) **Home care services**

_____ (INITIAL) **Accommodation, including placement in a long-term care home**

_____ (INITIAL) **With whom I may live and associate**

_____ (INITIAL) **Participation in social activities**

_____ (INITIAL) **Participation in educational activities**

_____ (INITIAL) **Participation in employment activities**

_____ (INITIAL) **Other personal matters** (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 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:

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 Delegate cannot consent to MAID on my behalf. If the law changes, here are my directions regarding MAID. I wish for my Delegate 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 WITNESS BELOW)

E5 **First name:** _____

E6 **Last name:** _____

E7 **Relationship to the "Maker":** _____

E8 **Signature:** _____

E9 **Address:** _____

E10 **Phone:** _____

E11 **Email:** _____

E12 **Date:** _____

DELEGATE #1

I agree to be the Delegate for the person who created this Personal Directive. I understand the responsibilities that come with this role.

E13 **First name:** _____

E14 **Last name:** _____

E15 **Signature:** _____

E16 **Date:** _____

DELEGATE #2 (OPTIONAL)

I agree to be the Delegate for the person who created this Personal Directive. I understand the responsibilities that come with this role.

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 Delegate or their spouse, or the person signing the Personal Directive for the Maker or their spouse.

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 Delegate(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 Personal Directive, re-read it to ensure your preferences are clear.** Then, review it with your Delegate(s). If a health care provider does not know you, they may need 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 ***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 Delegate(s) must ensure health care providers are provided with a copy of your Personal Directive. That is why you should appoint a Delegate.

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.