NUNAVUT

Personal Directive

A. NOTES

A1 **“Personal Directive” = Advance Directive**

A2 **“Guardian” = Substitute Decision-Maker**

A3 **In Nunavut, there is no legislation to enforce a Personal Directive. However, it is still beneficial to write down and talk about your wishes for future health care with loved ones and health care providers.**

A4 **A Guardian must be appointed by court order after you are no longer capable of making decisions about your health care, but the court can consider your wishes about who should fill this role.**

A5 **A Guardian must:**

- Be **18** years of age or older
- Be a Nunavut resident
- Have friendly, personal contact with the person applying for Guardianship within **12 months** of the application for Guardianship being made
- Consent to act on behalf of the person applying for Guardianship
- Be easily accessible to the person applying for Guardianship
- Be a suitable person and be able to act as the Guardian
- **NOT** be in a conflict of interest with the person applying for Guardianship

A6 **A witness should:**

- Be **18** years of age or older

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 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 GUARDIAN
(RECOMMENDED, BUT OPTIONAL)

C1 If I am no longer capable of making decisions about my health care, I wish for the following people to be appointed as my Guardian and Alternate Guardian and to make health care decisions for me:

GUARDIAN #1

C2 **First name:** ______________________________

C3 **Last name:** ______________________________

C4 **Relationship to me:** ______________________________

C5 **Address:** ______________________________

C6 **Phone:** ______________________________

C7 **Email:** ______________________________

ALTERNATE GUARDIAN

C8 **First name:** ______________________________

C9 **Last name:** ______________________________

C10 **Relationship to me:** ______________________________

C11 **Address:** ______________________________

C12 **Phone:** ______________________________

C13 **Email:** ______________________________

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)

____

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____

___________ (INITIAL) **OTHER** (please explain)

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

__________ **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**
(INITIAL)

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

__________ **At home**
(INITIAL)

__________ **In hospice**
(INITIAL)

__________ **In hospital**
(INITIAL)

D5 __________ **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.**
(INITIAL)

D6 __________ **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.**
(INITIAL)

ADDITIONAL DIRECTIONS:

____

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____

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____

____

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 Guardian cannot consent to MAID on my behalf. If the law changes, here are my directions regarding MAID. I wish for my Guardian 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:** ______________________________

GUARDIAN #1

I agree to be appointed as the Guardian for the person who created this Personal Directive in the future. I understand the responsibilities that come with this role, as set out in the ***Guardianship and Trusteeship Act***.

E13 **First name:** ______________________________

E14 **Last name:** ______________________________

E15 **Signature:** ______________________________

E16 **Date:** ______________________________

ALTERNATE GUARDIAN

I agree to be appointed as the Guardian for the person who created this Personal Directive in the future. I understand the responsibilities that come with this role, as set out in the ***Guardianship and Trusteeship Act***.

E17 **First name:** ______________________________

E18 **Last name:** ______________________________

E19 **Signature:** ______________________________

E20 **Date:** ______________________________

WITNESS

I certify that I witnessed the signing of this Personal Directive.

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 Guardian or Alternate Guardian changes

__________ **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 Guardian and Alternate Guardian. 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 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 Guardian(s) must ensure health care providers are provided with a copy of your Personal Directive. That is why you should appoint a Guardian.

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.