NEW BRUNSWICK

ADVANCE CARE DIRECTIVE: Instructions

In the Advance Care Directive Form below, you can set out your preferences for care should you lose capacity to make decisions. A separate document follows that allows you to appoint your Substitute Decision-Maker for Health, called an Attorney for Personal Care in New Brunswick.

Read the Advance Care Directive Form all the way through and do not start to fill it in until you have read the directions on how to do so.

1. Read each line carefully and strike out any that do not apply to you or that you do not agree with. There are extra spaces for you to fill in any circumstances not covered – e.g., you may have a hereditary condition you want to address.

2. Please pay special attention to Section 4 in the Advance Care Directive. If you **DO NOT WISH** to have your life prolonged under the conditions you have set out in Sections 1, 2, and 3, then you must strike out Section 4 completely. If you **DO WISH** to have your life prolonged under any circumstances, and are requesting all applicable medical treatment, then you must strike out Sections 1, 2, and 3 and leave only the directions you are giving under Section 4.

3. Although in New Brunswick you do not need a witness to your signature, we recommend that you have one.

4. Make copies of the Advance Care Directive Form before you sign and date, so that each has your original signature.

5. Give a copy of your Advance Care Directive to whoever you have appointed as your Attorney for Personal Care. Talk to your health care provider and ask that the Advance Care Directive be entered in your medical records. Keep a copy where it can easily be found in an emergency. Leave a note in a prominent place – perhaps with a fridge magnet – saying where to find your Advance Care Directive and who to call in an emergency. Do not store your Advance Care Directive in a locked safety deposit box.

CHANGING YOUR MIND:

You can always change your mind. We advise that you review your Advance Care Directive at least every three years. If there are no changes to be made, sign it again with the new date. There is space at the bottom of the form for you to do this. If your medical condition has changed, or if you have reconsidered some of the directions you wrote down, ask us to send you a new form and start over. Be sure to tell everyone involved in your care that you have revised your Advance Care Directive.

ADVANCE CARE DIRECTIVE: Form

I, ______________________________, revoke any previous Advance Care Directives written by me.

If the time comes when I lack the capacity to give directions for my health care, this statement shall stand as an expression of my wishes and directions.

If I am unable to make decisions only because I am being kept sedated, I would like the sedation lifted so I can rationally consider my situation and decide for myself to accept or refuse a particular therapy.

☐ Yes ☐ No

1. In any of the following circumstances, I direct that I receive only such care as will keep me comfortable and pain free, and that my dying not be prolonged:

a) An acute life-threatening illness of an irreversible nature

b) Chronic debilitating suffering of a permanent nature

c) Advanced dementia

d) ______________________________

e) ______________________________

2. In the circumstances set out in Section 1 above, I specifically refuse the following:

a) Electrical, mechanical, or other artificial stimulation of my heart

b) Respirator or ventilator

c) Artificial feeding, e.g., G tube, NG tube, or central intravenous line

d) Being fed, should I no longer be able to feed myself

e) Artificial hydration by intravenous line

f) Antibiotics

g) Transfer to an intensive care unit or similar facility

h) ____

i) ____

3. I specifically direct the following:

a) Provide necessary medication to control my pain and control my symptoms, even if such medication might shorten my remaining life

b) Provide me with palliative care

(You must choose only one option under 3c and strike out what does not apply)

c) I would prefer to be cared for and to die at home, **OR**

I would prefer to be cared for and to die in hospice, **OR**

I would prefer to be cared for and to die in hospital

d) ____

e) ____

Section 4 note: If you **DO NOT WISH** to have your life prolonged under the conditions you have set down in Sections 1, 2, and 3, you must strike out Section 4 completely. If you **DO WISH** to have your life prolonged under any circumstances and are requesting all treatment applicable to your medical condition, you must strike out Sections 1, 2, and 3 completely and leave only the directions you are giving under Section 4.

4. I specifically direct the following: I desire that my life be prolonged, and that I be provided all life-sustaining treatments applicable to my medical condition.

5. If my health care provider will not follow this Advance Care Directive, I ask that my care be transferred to another health care provider who will respect my legal rights.

6. If I should be a patient in a hospital, or resident in a health care or long-term care facility which will not follow this Advance Care Directive, I ask that I be transferred to another hospital or care facility.

Section 7 note: If you **DO NOT WISH** to provide directions regarding MAID, strike out this section. If you **DO WISH** to provide directions regarding MAID, write them below.

7. I understand that the current laws of Canada do not allow me to request medical assistance in dying ("MAID") in advance, or for my Attorney for Personal Care to consent to MAID on my behalf. However, if the law changes to allow my Attorney for Personal Care and health care providers to act on my directions below, I wish for them to do so. Here are my directions regarding MAID: ______________________________

____

____

____

Signature: ______________________________ Originally Dated: ____________________

Print Name: ____

Reviewed on ________________________ Signature: ____________________________

Reviewed on ________________________ Signature: ____________________________

Reviewed on ________________________ Signature: ____________________________

I have distributed this Advance Care Directive to the following people. This is a reminder to myself to keep these people informed of any changes. I am aware that outdated or defunct copies of this Advance Care Directive may create confusion if left in circulation.

Name(s) and phone number(s):

____

____

____

____

ATTORNEY FOR PERSONAL CARE: Instructions

The form for appointing your Substitute Decision-Maker for Health (called an Attorney for Personal Care in New Brunswick) is below.

1. You will need **two witnesses** to your signature. The witnesses **CANNOT** be the person you have appointed as your Attorney for Personal Care, or their spouse or child. Your witnesses must be 19 years of age or older.

2. If you are unable to sign the Attorney for Personal Care form, you may direct another person to do so on your behalf in your presence and the presence of your two witnesses. The person signing on your behalf **CANNOT** be your Attorney for Personal Care, their spouse, or their child.

3. In New Brunswick, an Attorney for Personal Care can be a stand-alone document or can be combined with an Attorney for Property. You can appoint the same person for both, or you can appoint one person for your personal and medical care, and a different person for your financial and legal affairs. If appointing an Attorney for Property, you must seek the advice of a lawyer.

4. **Please note:** You should consult with your lawyer if you wish to appoint multiple attorneys to act jointly; if you wish to have your Attorney for Personal Care combined with your Attorney for Property; if you feel you have special circumstances the Dying With Dignity Canada forms do not address. Seeking legal advice will ensure that you fully understand all of your available options and that your Attorney for Personal Care fulfills the legal requirements of your province. The form provided in this Advance Care Planning Kit is for the stand-alone Attorney for Personal Care. **It is strongly recommended that both you and your witnesses have your signature notarized by a lawyer or a notary public as some authorities will not accept the document otherwise**. Ask your lawyer or notary public for notarized copies of the signed Attorney for Personal Care Form, so that you and each of your Attorneys for Personal Care have a document with the original signatures and date. Keep your copy where it can be easily found in an emergency and leave a note in a prominent place giving the location of your Attorney for Personal Care Form and your Advance Care Directive Form, and who to call in an emergency. Do not store your copy of these documents in a locked safety deposit box.

CHANGING YOUR MIND:

You can always change your mind. Simply start off by stating that you revoke any previous Attorney for Personal Care and then continue to complete a new form in the same way as before. Make sure to inform your previous Attorney for Personal Care and anyone else to whom you gave a copy of the Attorney for Personal Care Form that you have made these changes.

ATTORNEY FOR PERSONAL CARE: Form

I, ___________________________________, revoke any previous Attorney for Personal Care I have made.

1. This Power of Attorney is given by ____ (Name)

of ____ (City) in the Province of New Brunswick.

2. I appoint ____ to be my Attorney for Personal Care in accordance with the Enduring Powers of Attorney Act.

3. If the above ____ should be or become at any time unable or unwilling to act in the office of attorney, then I appoint

____ to be my Attorney for Personal Care in accordance with the Enduring Powers of Attorney Act.

4. If both the above named ____ and the above named ____ should be or become at any time unable or unwilling to act in the office of attorney, then I appoint ___________________________________ to be my Attorney for Personal Care in accordance with the Enduring Powers of Attorney Act.

5. I give my Attorney for Personal Care authority to make decisions on my behalf for all personal matters of a non-financial nature that relate to me.

I have signed this Attorney for Personal Care in the presence of the witness whose name appears below.

I have signed this Attorney for Personal Care on ______________________________ (date)

Signature: ____

Attorney for Personal Care's Signature: ______________________________ Date: ______________

Alternate Attorney for Personal Care's Signature: ______________________________ Date: ______________

WITNESSES:

We have signed this Attorney for Personal Care in the presence of the person whose name appears above, and, on the date shown above.

Signature: ______________________________

Print Name: ______________________________

Address: ______________________________

Signature: ______________________________

Print Name: ______________________________

Address: ______________________________

Signature of lawyer or notary public: ______________________ Date: ______________

Apply stamp, type, or legibly print name: ______________________________