Central Jersey Ambulatory Surgery Center
Advance Directive/Living Will Declaration

Instructions: Consult this column for guidance.	To my family, Doctors, and all those concerned with my care
This declaration sets forth your decisions regarding medical treatment.	I, ______________________________, being of sound mind, make this statement as a directive to be followed if I become unable to participate in decisions regarding my medical care. If my death is near and cannot be avoided, or if I become comatose and lose the ability to interact with others and have no reasonable chance of regaining this ability, or if my suffering is intense and irreversible due to my mental or physical condition, I direct my attending physician to withhold or withdraw treatment that merely prolongs my dying. I further direct that treatment be limited to measures to keep me comfortable and to relieve pain.
You have the right to refuse the treatment you do not want, and you may request the care you do want.	These directions express my legal right to refuse treatment. Therefore, I expect my family, doctors, and everyone concerned with my care to regard themselves as legally and morally bound to act in accordance with my wishes, and in doing so to be free of any legal liability for having followed my directions.
You may list specific treatment you do not want: e.g., CPR, cardiac resuscitation-Mechanical respiration-Feeding Tubes-Intravenous Fluids. Your general statement above will suffice.	I especially do not want
You may want to add other instructions directing the care you do not want: e.g. pain management-to die at home.	Other instructions/comments
If you want, you can name someone to see that your wishes are carried out, but you do not have to do this.	PROXY DESIGN CLAUSE: In order to carry out my instructions as stated above and to interpret them, I designate the following person to act on my behalf Name:______________________ Address:______________________ Home Phone #:______________ Work Phone #:______________
	If the person named above is unable to act on my behalf, I authorize the following person to do so: Name:______________________ Address:______________________ Home Phone #:______________ Work Phone #:______________

Patient's Signature:______________________ Witness:______________________

Date:______________ Date:______________