AN ADVANCE DIRECTIVE IS A LEGAL DOCUMENT
YOU SHOULD KNOW THESE FACTS BEFORE SIGNING IT

This form allows you to choose who you want to make decisions about your health care when you cannot make decisions for yourself. This person is called your "agent." You should consider choosing an alternate in case your agent is unable to act. Agents must be 18 years old or older. They should be someone you know and trust. They cannot be anyone who is caring for you in a health care or residential care setting.

This form is an "advance directive" that defines a way to make medical decisions in the future, when you are not able to make decisions for yourself. It is a legal document giving direction for medical treatment (or refusing medical treatment.) It is not a medical order (e.g., it is not in and of itself a DNR (Do Not Resuscitate order) or POLST (Provider Order for Life Sustaining Treatment.)

You will always make your own decisions until your medical practitioner examines you and certifies that you can no longer understand or make a decision for yourself. At that point, your "agent" becomes the person who can make decisions for you. If you get better, you will make your own healthcare decisions again.

With few exceptions*, when you are unable to make your own medical decisions, your agent will make them for you, unless you limit your agent's authority in Part I.B of the durable power of attorney form. Your agent can agree to start or stop medical treatment, including near the end of your life. Some people do not want to allow their agent to make some decisions.

Examples of what you might write in include: "I do NOT want my agent . . .

- to ask for or agree to stop life-sustaining treatment (such as breathing machines, medically-administered nutrition and/or hydration (tube feeding,) kidney dialysis, other mechanical devices, blood transfusions, and certain drugs.)"
- to ask for or to agree to a Do Not Resuscitate Order (DNR order.)"
- to agree to treatment even if I object to it in the moment, after I have lost the ability to make health care decisions for myself."

** Exceptions: Your agent may not stop you from eating or drinking as you want. They also cannot agree to voluntary admission to a state institution; voluntary sterilization; withholding life-sustaining treatment if you are pregnant, unless it will severely harm you; or psychosurgery.*

The law allows your agent to put you in a clinical trial (medical study) or to agree to new or experimental treatment that is meant to benefit you if you have a disease or condition that is immediately life-threatening or if untreated, may cause a serious disability or impairment (for example new treatment for a pandemic infection that is not yet proven.)

You may change this by writing in the durable power of attorney for health care form:

- "I want my agent to be able to agree to medical studies or experimental treatment in any situation." Or
- "I don't want to participate in medical studies or experimental treatment even if the treatment may help me or I will likely die without it."

Your agent must try to make the best decisions for you, based on what you have said or written in the past. Tell your agent that you have appointed them as your healthcare decision maker. Talk to your agent about your wishes.

In the "living will" section of the form, you can write down wishes, values, or goals as guidance for your agent, surrogate, and/or medical practitioners in making decisions about your medical treatment.

You do not need a lawyer to complete this form, but feel free to talk to a lawyer if you have questions about it.

You must sign this form in the physical presence of 2 witnesses or a notary or justice of the peace for it to be valid. The witnesses cannot be your agent, spouse, heir, or anyone named in your will, trust or who may otherwise receive your property at your death, or your attending medical practitioner or anyone who works directly under them. Only one witness can be employed by your health or residential care provider.

Give copies of the completed form to your agent, your medical providers, and your lawyer.

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NEW HAMPSHIRE ADVANCE DIRECTIVE FORM

Name (Principal's Name): MARY A. MIDDLE
DOB: October 9, 1979
Address: 10 MAIN STREET, NASHUA, NH 00000

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

The durable power of attorney for healthcare form names your agent(s) and, if you wish, sets limits on what your agent can decide. If you choose more than one person, they will become your agent in the order written, unless you indicate otherwise

A. Choosing Your Agent: I choose the following person(s) as agent(s) to make health care decisions for me if I have lost capacity to make health care decisions (cannot make health care decisions for myself):

Name	City/State	Phone Number
Malcolm B. Middle	Nashua, NH	444-333-1111
Young M. Middle	Anytown, NH	555-111-2222
Suzie W. Middle	Anytown, NH	222-111-3333

If no one listed above can make decisions for you, a surrogate will be assigned in the order written in law (spouse, adult child, parent, sibling, etc.,) and will have the same powers as an agent. If there is no surrogate, a court appointed guardian may be assigned.

B. Limiting Your Agent's Authority or Providing Additional Instructions

When you can no longer make your own health care decisions, your agent will be able to make decisions for you. Please review the Disclosure Statement that is attached to this advance directive for examples of how you may want to advise your agent. You may write in limits or additional instructions below or attach additional pages.

Life Sustaining Treatment

__✓__ My agent may ONLY ask for or agree to those forms of life-sustaining treatment that I would not consider to be excessively burdensome AND that have a reasonable hope of benefit for me. I do NOT wish to have any life-sustaining treatment attempted that would not have a reasonable hope of benefit for me or that would be considered excessively burdensome. If I have any additional restrictions regarding life-sustaining treatment, they are listed below.

__✓__ My agent may NOT ask for or agree to life-sustaining treatment if I am **actively dying** (medical treatment will only prolong my dying.)

__✓__ My agent may NOT ask for or agree to life-sustaining treatment if I become **permanently unconscious** with no reasonable hope of recovery.

__✓__ My agent may NOT ask for or agree to life-sustaining treatment if I suffer from an **advanced life-limiting, incurable and progressive condition (including but not limited to advanced Alzheimer's Disease or advanced dementia)** and if the likely risks and burdens of treatment would outweigh the expected benefits. If I want my agent to take any further action regarding advanced life-limiting, incurable and progressive conditions, they are listed below.

__✓__ If I lose the ability to speak for myself (due to dementia,) and I am currently receiving any **medications or treatments** that are likely to extend my life or prolong my dying process, I want those stopped.

__✓__ I request that **food and fluids** in any form, including spoon-feeding, be stopped if (because of dementia) any of the following conditions repeatedly occur: I appear indifferent to food and being fed; I no longer appear to desire to eat or drink; I do not voluntarily open my mouth to accept food without prompting; I turn my head away or try to avoid being fed or given fluids and am clearly repelled by food or fluids; I spit out food or fluids; I cough, gag, choke on, or inhale food or fluids; or the negative consequences or symptoms of continued feeding and drinking, as determined by a qualified medical provider, outweigh the benefits.

If the above statement regarding food and fluids goes into effect for any of the above listed reasons, and as a result I begin to experience **delirium, agitation or hallucinations**, then I would like my medical

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team to provide **palliative sedation** in order to avoid suffering until death occurs. I want the instructions in this provision followed even my agent judges that my quality of life, in their opinion, is satisfactory and I appear to them to be comfortable.

Treatment Over My Objection
_✓_ My agent may NOT ask for or to agree to treatment if I object to it after I have lost the ability to make health care decisions for myself.

Medical Studies/Experimental Treatment
_✓_ My agent may NOT ask for or to agree to my participation in medical studies or experimental treatment even if the treatment may help me or I will likely die without it.

My Body
I request cremation, then burial, in our family plot.

SIGNATURE

I have received, reviewed, and understood the disclosure statement, and I have completed the durable power of attorney for health care consistent with my wishes.

Signed this ___ day of __________, 20___

Principal's Signature: ____________________
If you are physically unable to sign, this advance directive may be signed by someone else writing your name in your physical presence at your direction.

THIS ADVANCE DIRECTIVE MUST BE SIGNED BY TWO WITNESSES OR A NOTARY PUBLIC OR A JUSTICE OF THE PEACE.

We declare that the principal appears to be of sound mind and free from duress at the time this advance directive is signed and that the principal affirms that the principal is aware of the nature of the directive and is signing it freely and voluntarily.

Witness: _______________ Address (city/state): ____________________

Witness: _______________ Address (city/state): ____________________

STATE OF NEW HAMPSHIRE
COUNTY OF MERRIMACK
The foregoing advance directive was acknowledged before me this ___ day of __________, 20___, by __________ (the "Principal.")

____
Notary Public/Justice of the Peace
My commission expires:

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