Advance Health Care Directive (NJ)
Preparation Form

This Preparation Form will help you gather your personal information prior to filling out the Questionnaire online so you can quickly and efficiently create your custom document. Please complete all applicable sections as completely as possible. **If any information is not readily available, we recommend you gather this information prior to commencing the online session so you may complete your document.**

If you have any questions as you work on the questionnaire, please contact us at info@helixcompliance.com.

Your General Information

Your Full Legal Name: ______________________________

County of Residence: ______________________________

Health Care Representative's Information

Rep's Full Legal Name: ______________________________

Rep's Address: ______________________________

State of Residence: ______________________________

Zip Code: ______________________________

Phone Number: ______________________________

Alternate Health Care Representative's Information

Alt. Rep's Full Legal Name: ______________________________

Alt. Rep's Address: ______________________________

State of Residence: ______________________________

Zip Code: ______________________________

Phone Number: ______________________________

Duration of Advance Health Care Directive

When would you like your advance health care directive to expire?

☐ **I would like the advance directive to remain in effect indefinitely.**

☐ **I would like the advance directive to expire on a specific date:** ____________________

Health Care Questions

If I am in an incurable or irreversible mental or physical condition with no reasonable expectation of recovery, I direct my attending physician to withhold or withdraw treatment that merely prolongs my dying, such as:

CHECK ALL THAT APPLY

☐ **I do not want cardiac resuscitation (CPR).**

☐ **I do not want mechanical respiration (Intubation).**

☐ **I do not want artificial nutrition or hydration (Feeding Tubes).**

☐ **I do not want antibiotics.**

Note: Unless your desires regarding Artificial Nutrition and Hydration (feeding tubes) are known, a hospital or institution may be required to administer artificial hydration and nutrition.

If I am in an incurable or irreversible mental or physical condition with no reasonable expectation of recovery, I direct my attending physician to provide maximum pain relief, even if it hastens my death?

☐ **Yes**

☐ **No**

Do you wish to donate your organs, tissues, and other parts on your death?

☐ **Yes**

☐ **No**

If Yes, do you want to donate all needed organs, or only specific organs?

☐ **I wish to give any needed organs, tissues, or parts on my death.**

☐ **I wish to give the following organs, tissues, or parts only:**

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