



## Personal Directive

I, \_\_\_\_\_, make this Personal Directive.  
Name of Maker

This Personal Directive is made pursuant to the Personal Directives Act and takes effect if I am not capable of making a decision regarding my personal care.

I have placed my initials and my witness has placed his/her initials next to the sections in this document that I want to be part of my Personal Directive.

#### 1. Consultation when assessing capacity (optional)

The person making the assessment of my capacity is to consult with the following person when making the assessment.

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Witness' Your  
Initials Initials

Name: \_\_\_\_\_  
Print Name, Title or Position of Individual

Address: \_\_\_\_\_  
                  Street Address

City/Town \_\_\_\_\_ Province \_\_\_\_\_

Witness' Your  
Initials Initials

## 2. Revoking (Cancelling) Other Directions (optional)

I revoke (cancel) all previous instructions, personal directives, and authorizations, including those made pursuant to the Medical Consent Act.

OR

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Witness' Initials      Your Initials

I revoke (cancel) only the following instructions, personal directives or authorizations:

Date:

Description:

### 3. Authorization to Act as Delegate (optional)

\_\_\_\_\_  
Witness' Initials    Your Initials

I authorize the following person to act as my delegate to make personal care decisions on my behalf for all personal matters, of a non-financial nature, that relate to me.

Name: \_\_\_\_\_

Print Name of Delegate

Address: \_\_\_\_\_

Street Address

City/Town

Province

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Home

Business

If my delegate is unable, unwilling or unavailable to make a personal care decision, I authorize the following person to act as my alternate delegate.

Name: \_\_\_\_\_

Print Name of Alternate Delegate

Address: \_\_\_\_\_

Street Address

City/Town

Province

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Home

Business

**OR**

\_\_\_\_\_  
Witness' Initials    Your Initials

I want to authorize more than one delegate to make different personal care decisions on my behalf. I authorize the following individuals to act as my delegates and alternate delegates (if the delegate is unable, unwilling or unavailable to make a personal care decision) to make personal care decisions on my behalf for all the following personal care matters, of a non-financial nature, that relate to me:

health care

\_\_\_\_\_  
Name of Delegate and contact information

\_\_\_\_\_  
Name of Alternate Delegate and contact information

home care services

\_\_\_\_\_  
Name of Delegate and contact information

\_\_\_\_\_  
Name of Alternate Delegate and contact information

accommodation, including placement in a continuing-care home	Name of Delegate and contact information	Name of Alternate Delegate and contact information
with whom I may live and associate	Name of Delegate and contact information	Name of Alternate Delegate and contact information
participation in social activities	Name of Delegate and contact information	Name of Alternate Delegate and contact information
participation in educational activities	Name of Delegate and contact information	Name of Alternate Delegate and contact information
participation in employment activities	Name of Delegate and contact information	Name of Alternate Delegate and contact information
other personal care matters as follows:	Name of Delegate and contact information	Name of Alternate Delegate and contact information

#### 4. No Delegate Authorized (optional)

\_\_\_\_\_  
Witness' Initials      Your Initials

I DO NOT wish to authorize a delegate, but have provided instructions in section 5  
for persons who intend to provide personal care services to me.

#### 5. Specific Instructions (optional)

I instruct my delegate(s) to carry out the following specific instructions when  
making decisions about my personal care:

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additional page attached?    Yes    No

\_\_\_\_\_  
Witness' Initials      Your Initials

If I have not designated a delegate(s), or if my delegate(s) and alternate delegate(s) are unable, unwilling or unavailable to make a personal care decision, I instruct all persons who intend to provide personal care services to me to follow the following instructions that are relevant to the decisions to be made:

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additional page attached?  Yes  No

\_\_\_\_\_  
Witness' Initials      Your Initials

## 6. Other Information (optional)

I provide the following information to help my delegate(s) or statutory decision-maker understand my values, beliefs and wishes when making decisions about my personal care:

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additional page attached?  Yes  No

\_\_\_\_\_  
Witness' Initials      Your Initials

## 7. Instructions about Statutory Decision-makers (optional)

I **DO NOT** wish to authorize a delegate and am comfortable with a relative authorized under section 14 of the Personal Directives Act making decisions on my behalf about health care, home care and placement in a continuing care home, except I **DO NOT** want the following relative(s) making decisions on my behalf:

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Name

Relationship

## 8. Consultation when Delegate Making Decisions (optional)

Witness' Your  
Initials Initials

My delegate(s) is to consult with the following person(s) when making decisions about my personal care.

Name: \_\_\_\_\_  
Print Name of Delegate

Address: \_\_\_\_\_  
Street Address

City/Town \_\_\_\_\_ Province \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
Home Business

## 9. Notification (optional)

Witness' Your  
Initials Initials

If it is determined that I lack capacity to make a personal care decision, I instruct the person making the determination to notify me, the delegate(s) I have authorized in this Personal Directive, if any, and the following people:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Witness' Your  
Initials Initials

If it is determined that I lack capacity to make a personal care decision, the following people are not to be notified of the determination:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## 10. Compensation for Personal Care Services (optional)

Witness' Your  
Initials Initials

My delegate, \_\_\_\_\_, is authorized to receive compensation for providing me with personal care services on the following terms:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### 11. Remuneration for Delegate (optional)

Witness' Initials \_\_\_\_\_ Your Initials \_\_\_\_\_

My delegate, \_\_\_\_\_, is authorized  
Name of Delegate  
to receive remuneration for exercising his/her authority under this personal directive  
on the following terms:

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### 12. Signatures (mandatory)

Signed by me in the presence of my witness at \_\_\_\_\_, in the Province of \_\_\_\_\_  
Location

Nova Scotia, this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.  
Day Month Year

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Printed Name of Witness

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Printed Name of Maker

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Relationship to Maker

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Signature of Maker in the presence of the Witness

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Signature of Witness in the presence of the Maker

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Street Address

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Street Address

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City/Town

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City/Town

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Province

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Province

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Home Phone Number      Business Phone Number

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Home Phone Number      Business Phone Number

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Email

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Email

**OR (where Maker physically unable to sign)**

Signed on behalf of the Maker, \_\_\_\_\_, in the presence of the  
Name of Maker

Maker and in the presence of the witness at \_\_\_\_\_, in the Province of  
Location

Nova Scotia, this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.  
Day Month Year

Print Name of Person signing on behalf of Maker

Print Name of Witness

Relationship to Maker

\_\_\_\_\_  
Signature of Person signing on behalf of Maker  
in the presence of the Maker

\_\_\_\_\_  
Signature of Witness in the presence of the Maker

Street Address

Street Address

City/Town

City/Town

Province

Province

Home Phone Number

Business Phone Number

Home Phone Number

Business Phone Number

Email

Email