



1500001

WRITE YOUR NAME, DATE OF BIRTH, & HOSPITAL MEDICAL RECORD NUMBER (IF KNOWN)

VIRGINIA ADVANCE DIRECTIVE FOR HEALTH CARE STANDARD FORM

I, \_\_\_\_\_, willingly and voluntarily make known my wishes in the event that I am incapable of making an informed decision about my healthcare, as follows:

If you only wish to APPOINT AN AGENT and not specify instructions - COMPLETE SECTION 1; cross out Section 2 and/or 3; sign 4.

Section 1: APPOINTMENT OF AN AGENT FOR HEALTH CARE DECISIONS

I hereby appoint the following as my primary agent to make health care decisions on my behalf as authorized in this document: (please print)

Primary agent name \_\_\_\_\_ Day/cell phone \_\_\_\_\_
Address \_\_\_\_\_ Evening phone \_\_\_\_\_
Email \_\_\_\_\_ Relationship to patient \_\_\_\_\_

If my primary agent is not reasonably available or is unable or unwilling to make health care decisions for me, I appoint the following person as my substitute agent:

Substitute agent \_\_\_\_\_ Day/cell phone \_\_\_\_\_
Address \_\_\_\_\_ Evening phone \_\_\_\_\_
Email \_\_\_\_\_ Relationship to patient \_\_\_\_\_

My health care agent(s) shall make healthcare decisions based on my previously expressed wishes and my personal beliefs and values. If my agent cannot determine what health care choice I would have made on my own behalf, then I want my Agent to make a choice for me based upon what he or she believes to be in my best interests. The powers of my Agent are outlined in the Virginia Health Care Decisions Act 54.1-2984 and listed in TALKING ABOUT YOUR HEALTH CARE CHOICES, attached to this form.

HEALTH CARE FACILITY VISITATION: You may provide direction here. If you leave this blank, your agent can make decisions about who may visit and/or who may be restricted from visiting (unless clinically restricted).

My directions for visitation are: \_\_\_\_\_

SECTION 2: MY HEALTH CARE INSTRUCTIONS

You may use any or all of the parts in this section to direct your health care even if you do not have an agent. If you choose not to provide written instructions, decisions will be based on your values and wishes, if known, and otherwise on your best interests.

I provide the following instructions in the event my attending physician determines that :

- my death is imminent (very close) and medical treatment will not help me recover;
• my condition makes me unaware of myself or my surroundings or unable to interact with others, and it is reasonably certain that I will never recover this awareness or the ability even with medical treatment:

On the next page, put your initials in ONLY ONE box in this section.

**Please put your initials in ONLY ONE box in this section to indicate your instructions:**

- I do not want any treatments to prolong my life. This includes tube feeding, IV fluids, cardiopulmonary resuscitation (CPR), ventilator/respirator (breathing machine), kidney dialysis or antibiotics. I understand that I still will receive treatment to relieve pain and make me comfortable.  
**OR**
- I want all treatments to prolong my life as long as possible within the limits of generally accepted health care standards, I understand that I will receive treatment to relieve pain and make me comfortable.  
**OR**
- I want to try treatments for a period of time in the hope of some improvement of my condition. I suggest \_\_\_\_\_ as the period of time after which such treatment should be stopped if my condition has not improved. The exact time period is at the discretion of my agent or surrogate in consultation with my physician. I understand that I still will receive treatment to relieve pain and make me comfortable.  
**OR**
- I provide the following instructions concerning my health care:  
*You may write statements and instructions about treatments that you do want, if medically appropriate, or about treatments you do not want under specific circumstances or any circumstances. It is important your instructions here do not conflict with other instructions you have given in this directive. If you have other instruction documents, please attach to this form or note the location. (If you are, or may become pregnant, you may wish to provide specific instructions related to health care decisions during your pregnancy.)*  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SECTION 3: ANATOMICAL GIFTS**

*You may use this section to record your decision about donating your organs, eyes and tissues or your whole body after your death. If you do not make this decision here or in any other document, your agent can make the decision for you unless you specially prohibit him/her from doing so. You may write statements and instructions about anatomical gifts here or in another document.*

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

**SECTION 4: AFFIRMATION / RIGHT TO REVOKE / SIGNATURE**

By signing below, I state that I am emotionally and mentally capable of making this advance directive and that I understand the purpose and effect of this document. I understand that I may revoke or change all or any part of this document at any time: (i) with a signed, dated document; (ii) by physical cancellation or destruction of this advance directive by myself or by directing someone else to destroy it in my presence; or (iii) by my oral expression of intent to revoke to my attending physician.

My Signature: \_\_\_\_\_  
*Declarant* *Date*

I have seen this person sign the advance directive form in my presence: (Witnesses must be adults - 18 years and older)

\_\_\_\_\_  
*Witness Printed Name* *Signature*

\_\_\_\_\_  
*Witness Printed Name* *Signature*

*This form satisfies the requirements of Virginia's Health Care Decisions Act and was adapted from the Virginia Hospital and Healthcare Association form, June 2012.*

**INTERPRETER ATTESTATION:** Interpretation has been provided by:

# Talking About Your Health Care Choices

## Planning for future medical care

You, as an adult (18 years and older), have the legal right to make choices about medical care in case you become too sick or injured to speak for yourself. Providing instructions helps lift some of the burden of decision making from your loved ones. You may designate the person of your choice to be your agent.

## What are the powers of my agent?

There are forms available that allow you to give specific powers to your agent.

Completing this STANDARD form gives all the powers listed below to your agent:

1. To consent to or refuse or withdraw consent to any type of health care, including, but not limited to, artificial respiration (breathing machine), artificially administered nutrition (tube feeding) and hydration (IV fluids), and cardiopulmonary resuscitation (CPR). This authorization specifically includes the power to consent to dosages of pain-relieving medication in an amount sufficient to relieve pain. This applies even if this medication carries the risk of addiction, inadvertently hastens my death or is in excess of commonly recommended dosages.
2. To request, receive and review any oral or written information regarding my current physical or mental health, including but not limited to medical or hospital records, and to consent to the disclosure of this information as necessary to carry out my directions as stated in this advance directive that I am admitted to any healthcare facility.
3. To employ or discharge my health care providers.
4. To authorize my admission, transfer, or discharge to or from a hospital, hospice, nursing home, assisted living facility or other medical care facility.
5. To authorize my admission to a health care facility for treatment of mental illness as permitted by law. (If I have other instructions for my agent regarding treatment for mental illness, they are stated in a supplemental document.)
6. To continue to serve as my agent if I object to the agent's authority after I have been determined to be incapable of making an informed decision.
7. To authorize my participation in any health care study approved by an institutional review board or research review committee according to applicable federal or state law if the study offers the prospect of direct therapeutic benefit to me.
8. To authorize my participation in any health care study approved by an institutional review board or research review committee according to applicable federal or state law that aims to increase scientific understanding of any condition that I may have or otherwise to promote human well-being, even though it offers no prospect of direct benefit to me.
9. To make decisions regarding visitation during any time that I am admitted to any health care facility except as noted in Section 1 on Page 1 of the form.
10. To take any lawful actions that may be necessary to carry out these decisions, including the granting of releases of liability to medical providers.

*BACK OF WALLET CARD*

*OVER*

# Talking About Your Health Care Choices continued

## What is Advance Care Planning?

Advance care planning is a process to make and write down decisions about future medical care. It includes:

- **Understanding** your current health, the choices you may make about treatment options.
- **Thinking about** what is important to you and gives your life meaning; balancing quality of life with medical care (the benefits and burdens of your choices); people you trust to speak for you if you cannot speak for yourself.
- **Choosing an Agent** (makes health care decisions for you if you cannot speak for yourself). Consider:
  - Is the best person to make decisions that honor MY wishes?
  - Is the person willing and able to be a strong voice for me?
- **Talking** with your Agent, family, and health care team to clarify your choices (if you say, “no heroics “or “do everything” – what does that mean?).
- **Put your decisions in writing.** Be sure your Advance Directive is on file with all your doctors and hospitals so it is readily available. Carry the wallet card, below, stating where your form is located.

## What is an Advance Directive?

- An Advance Directive is a legal document that explains your decisions about future medical care.
- You make decisions for yourself when possible. If two physicians (or a physician and licensed psychologist) determine that you are incapable of making health decisions we ask your agent(s). If you wish to choose specific powers for your agent, you need to complete a "long" Advance Directive form. See below for sources.
- To be legal you must sign and date it, and have two adults sign it showing they witnessed your signature.
- You may also wish to reference or attach other documents such as a letter to your family or a “values history”.
- Every year, or if your health changes, review your Advance Directive to see if it still matches your goals and if any information needs to change (for instance the agent name or contact information).
- If you do not have an Advance Directive, decisions are made by adults named by law in this order:
  - guardian, spouse (except when divorce has been filed), adult children, parent(s),
  - adult brothers/sisters, or others (after discussion with the health care team).

## How can I learn more?

- Every hospital and many organizations offers information on their website and individuals who will talk to you about Advance Care Planning. Detailed information is available from: <http://www.virginiaadvancedirectives.org/>
- For more information about organ, tissue, eye donation, or to register visit: [www.donatelifevirginia.org](http://www.donatelifevirginia.org)
- For more information about Durable Do Not Resuscitate Orders call the Virginia Office of EMS at 1-800-523-6019 or visit the VDH website.
- For Advance Care Planning information and forms from each state, visit: [www.caringinfo.org](http://www.caringinfo.org)
- The Conversation Project has tools to help you talk about your wishes, visit: [www.theconversationproject.org/](http://www.theconversationproject.org/)
- In Virginia, there are Durable Do Not Resuscitate Order (DDNR) and Physician Orders for Scope of Treatment (POST) forms. These are for people of any age who are seriously ill or frail. They are available from your doctor. Both you and your doctor sign them. Your agent does not have authority to change orders in a DDNR form signed by you.
- When in the hospital your health care team will talk to you (or your agents) about your goals and will review an advance directive (if available). Orders will be written to carry out the plan.

**CUT OUT AND FOLD WITH THIS SIDE OUT. CARRY THIS CARD IN YOUR WALLET.  
ADD COMMENTS OR DETAILS ON OTHER SIDE.**

<p><b>NOTICE TO HEALTH CARE PROVIDERS</b></p> <p>I, _____, <i>(Print full name)</i></p> <p>have an Advance Directive. I have named the following as my Agent for Health Care Decisions:</p> <p>1<sup>st</sup> Agent: _____ Phone: _____</p> <p>2<sup>nd</sup> Agent: _____ Phone: _____</p>	<p>A copy of this document is on file with: <i>(Name/Address of Hospital, Registry or Person)</i></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>My doctor’s name and phone number:</p> <p>_____</p> <p>_____</p>
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