Instructions for Health Care Advance Directive

Included in this packet:

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Glossary of Terms

Agent: The person or persons you choose to make decisions for you whenever you cannot do so for yourself; this should be someone you trust to make important decisions for you, someone who is willing to do so, someone who can be easily reached in an emergency, and someone who knows or can learn about your specific health-care needs and wishes.

Best interests: If at all possible, your agent must do whatever he knows you would do or would want to do if you could make your own choices. However, if your agent doesn't know what you would choose, he must make the decision that seems the best for you given the circumstances.

Capacity: The ability to listen to information about your options, make a choice, and communicate your choice. People take in information and communicate their choices in different ways. Just because you may need assistance or communicate differently (such as with an interpreter or with a communication device or with pictures) does not mean you do not have capacity. Information should be given to you in a way you can understand it and you should get whatever help you need to make and communicate your choices. Our law says that you have capacity until either a judge or two doctors decide you do not and put their decision in writing. That means that you can legally make decisions about your health care and about your Power of Attorney so long as you have not been found to lack capacity by a judge or two doctors.

Consent: Making a decision about medical care. You can either give consent which means saying "yes" to treatment or you can refuse consent which means saying "no" to treatment.

Durable Power of Attorney: A "durable" Power of Attorney stays in effect even if you get sick or hurt and don't have capacity to make your own choices at the time they need to be made. When that happens, your agent starts making decisions for you until you get better and you are able to make your own decisions again.

Health care: care for all of your body, including your physical health and your mental health.

Health-care study: sometimes called "experimental treatment", this is treatment that may or may not help you; every medication ever used on human beings has gone through a time of testing to see if it works the way scientists think it does; if you agree to be in a health-care study, you will be told about the possible benefits (good things that might happen) and side-effects (bad things that might happen) before you make your decision about doing it.

HIPAA: stands for Health Insurance Portability and Accountability Act**;** this is a long and complex federal law, but here, we simply mean the part of the law that protects your private health-care information from being released to anyone without your permission.

Incapable of making an informed decision: this is another way of saying "incapacity" or "lacking capacity"; it is the opposite of "capacity", so it means not being able to listen to information, make a choice or communicate a choice.

Incapacity: not being able to listen to information, make a choice or communicate a choice; the opposite of "capacity".

Licensed health care provider: as used in this document, includes an attending licensed physician, a licensed clinical psychologist, a licensed physician assistant, a licensed nurse practitioner, a licensed professional counselor, or a licensed clinical social worker.

Life-prolonging treatment: medical care that will not make you better but may extend your life; the types of care that we usually mean when we talk about "life-prolonging treatment" include a ventilator to make your lungs work when you cannot breathe on your own, a feeding tube to take in food when you cannot eat food through your mouth, and IV fluids when you cannot swallow; these treatments are used to keep the body alive past the time the body would die if they were not used.

Persistent vegetative state: a condition that causes a person to be unaware of his surroundings and incapable of voluntary action or thought.

Principal: You! The person making the decisions in the Power of Attorney and signing it.

A note on pronouns: This document uses the masculine pronouns "he" and "him". Reference to only one gender is intentional and is done solely for simplicity and ease of reading.

Specific Instructions for Each Line in the Sample Advance Directive

1

This line is for your full legal name. Make sure you put your full name here and make sure it is your legal name and not a nickname. If you have a nickname or a name you prefer rather than your legal name, put your full legal name first and then put your preferred name in parentheses. For example, if your name is John Henry Doe but you prefer to be called Jack, you would fill out this line like this: John Henry Doe (Jack). If you have ever been known by a different name and you think it might be confusing if your family or others use your previous name, include it as an AKA (also known as) or note it as "previously known as". For example, if your name given at birth was Cassius Marcellus Clay Jr. and you legally changed your name to Muhammad Ali, it would look like this: Muhammad Ali (previously known as Cassius Marcellus Clay Jr.).

2

Fill in your birthday here. Your birthday is often used as a way to identify you. There may be two people named John Henry Doe in the hospital, but they probably don't have the same name and the same birthday. You can write your birthday in numbers or words. For example, if your birthday is January 1, 2015, you can write it as January 1, 2015 or 1/1/2015 .

3

Your "agent" is the person you choose to make decisions for you whenever you can't. The person you choose to be in this number-one slot will be the first person the doctor talks to if a decision needs to be made for you, so in this slot you will put the person you want to have that responsibility. On this line, put the person's full legal name. Just as in line 1, make sure you put the full legal name and if the person has another name they prefer to be called or a previous name, put that name in parentheses after the legal name.

4

Put the person's address on this line. If you don't know the address, call the person and ask for it. If they have a post office address, put both the post office address and the physical address on this line. For example, if your agent has a post office address, this line might look like this: 1234 Main Street, Anywhere, Virginia, 12345 (P.O. Box 4321, Anywhere, Virginia, 12345).

5

Put all phone numbers for the person on this line and identify the type of number in parentheses after each number. Possible numbers include home, cell, work, work cell, etc. Make sure you include the area code for every number and include an extension if there is one. The line might look like this: 434-555-1234 (home); 540-555-2345 (cell); 804-555-3456 ext. 24 (work).

6

You have the option of choosing a substitute or alternate agent in case your number-one choice is not available. Most of the time, we choose one of the most important people in our lives as that number-one choice and we probably spend a lot of time with that person. What would happen if you were both in the car when there was an accident and your number-one person was also hurt? In that situation, it would be very helpful to have a second person in line to help out. That's what this line is for—to choose that second person. You'll notice there are spaces for four people on this paper. You may choose any number of people as your agents. If you choose less than four, you can leave the unused ones blank or you can cross them out.

7

In most circumstances, four choices for an agent is plenty (two is the most common number). However, if you want more that four, you can check this box and add the others on another piece of paper you can attach to the advance directive. Fill out the names, addresses and phone numbers following the instructions for lines 3, 4, and 5.

8

You don't have to do anything to this paragraph. It describes the power you are giving your agent and when that power is in effect. Your agent has no power to make decisions for you unless you don't have the capacity to do so for yourself and two doctors agree that you don't and

they put their decision in writing. Once you get better and one doctor says you can make your own decisions again, your agent goes back to not having any power to make decisions for you.

9

You don't have to do anything to this paragraph. It states that your agent must do whatever he knows you would do or would want to do if you could make your own choices. This means that if your agent knows what choice you would make if you could, then your agent must make that choice for you even if he doesn't agree with it. However, if your agent doesn't know what you would choose, he must make the decision that seems to be in your best interest given the circumstances.

10

This section outlines the powers your agent can have over your medical care. You can chose to give your agent all of the powers listed or you can cross through those that you do not want your agent to have. However, you need to consider carefully how much you limit your agent's authority because you could take away powers that are essential for the agent to do his or her job. The following list includes explanations of the powers and the effects of limiting each power so that you can make an informed decision. The following scale will be used when explaining the effect of limiting powers:

- **Extremely important**: If you remove this power, your agent will not be able to do the job and your entire advance directive will be weakened or negated.
- **Very important**: If you remove this power, it will be very difficult for your agent to do the job and your advance directive will be weakened.
- **Important**: If you remove this power, your agent will not be able to make certain decisions that may affect your treatment, but the power to make other decisions will not be affected.
- **Optional**: If you remove this power, your agent will not be able to do a specific thing, but the rest of the powers are not affected.

A. To provide or refuse consent to any type of medical treatment, medication and procedures

- This is the basic power to say "yes" or "no" to medical treatment.
- Effect of limiting power: If you remove this power, your agent will not be able to make any medical decisions for you and would basically negate the entire document.
- **This power is extremely important**.

B. To make decisions about life-prolonging treatment

- This allows your agent to make decisions for you when you are either at the end of your life or in a persistent vegetative state. Decisions at this time of life include whether to use life-prolonging treatments and machines such as ventilators and feeding tubes to keep your body alive when it can no longer complete these functions on its own. It is important to understand that you may need **temporary** life-sustaining treatment after an illness, injury or surgery in order for your body to heal. That is different from life-prolonging treatment that is expected to be **permanent** with no expected chance of surviving without it. This is a very personal decision and is often based on your values, religious beliefs and life experiences. Many people have not thought about these difficult choices and prefer not to do so. That's okay. Here, you are just deciding whether you want your agent to make those decisions if it's ever necessary. You can also put your wishes in writing later in this document (see Lines 31-37) so that your agent, doctors and loved ones will know exactly what you want.

- Effect of limiting power: If you have specific instructions in this document (Lines 31-37), those instructions will be followed. If you have not written down your instructions and do not give your agent the power to make the decision, your doctor will go to your next-of-kin to make the decision (spouse, adult children, parents, siblings, other blood relatives—in that order). If there is more than one person to make the decision, they may not agree and they might argue over the decision. It is best to make your wishes known and/or appoint someone to make these decisions. If you do not do so, you may get care you don't want or not get the care you do want.
- **This power is important**.

C. To request, receive, and review any information, oral or written, about my health care and to consent to the disclosure of this information. I intend that this grant of authority shall meet the requirements of HIPAA and that my agent shall have full access and authority over my medical information

- This power allows your agent to talk to your doctors, get information on your diagnosis and treatment options and release that information to others in order to get you the care you need.
- Effect of limiting power: If your agent does not have this power, he will not be able to make informed decisions about your care and treatment. He will not be able to get information from your doctors or give information to the people who need it to care for you.
- **This power is extremely important**.

D. To hire and fire my health care providers

- This power allows your agent to get a second opinion from a new doctor, find you a new doctor if you get a different diagnosis and need a different type of doctor, and get rid of a doctor who is no longer meeting your needs or following your wishes.
- Effect of limiting power: Without this power, your agent would not be able to get a second opinion for serious health conditions or get you to a different doctor if your current doctor cannot meet your needs.
- **This power is very important.**

E. To make decisions regarding visitation consistent with any wishes known by my agent during any time that I am admitted to any health care facility

- This power allows your agent to limit who may come to see you when you are in the hospital. The hospital may have its own rules (for example, only family members can visit you if you are in the intensive care unit) and your agent cannot override those rules, but if you give your agent this power, he may create even stricter limitations. This power may be particularly helpful if there are people in your life who you would not want to visit you. You can also put your specific wishes in writing later in this document (see Line 28).
- Effect of limiting power: If you remove this power, your agent will have no say over who may visit you and will not be able to limit visitors. The only limitations on visitors will be the rules of the hospital and ward where you are receiving treatment.
- **This power is optional.**

F. To authorize my participation in any health care study approved according to applicable federal or state law that offers the prospect of direct therapeutic benefit to me

- This power allows your agent to consent to your participation in experimental treatment such as new drug trials. Sometimes a doctor suggests an experimental drug or treatment when all other methods have not worked and sometimes a doctor thinks the experimental drug or treatment offers the best hope for a cure. In some trials, only half of the participants get the drug or treatment while the rest get a placebo (a harmless pill or treatment that has no benefit to the person) and you may not know which group you are in.
- Effect of limiting power: If you remove this power, your agent will not be able to consent to any experimental drug or treatment offered by your doctor.
- **This power is generally optional but could be important for certain types of illnesses.**

G. To authorize my participation in any health care study approved according to applicable federal or state law that aims to increase scientific understanding or to promote human well-being, even though it offers no prospect of direct benefit to me

- This power is similar to that in Paragraph F, but there is an important distinction—this paragraph refers to participation in scientific research when it will not directly help you get better. For example, if you have a rare disease, doctors may want to study it in order to create better options for treating it in the future. It won't help you, but it could lead to a cure or treatment that could help someone else.
- Effect of limiting power: If you remove this power, your agent will not be able to consent to your participation in scientific studies if it will not benefit you but would possibly benefit others.
- **This power is optional.**

H. To authorize my admission to or discharge from any hospital, hospice, nursing home or other medical care facility, not including a mental health facility

- This power allows your agent to get you into the type of medical facility necessary to meet your medical needs and to get you out of those facilities when you no longer need them.
- Effect of limiting power: If you remove this power, your agent will not be able to admit you to a facility to meet your needs if they cannot be met as an outpatient. You would still be admitted for any emergency care, but your agent would not be able to admit you for other treatment such as non-emergency care, surgery or long-term care. Your agent will also not be allowed to make discharge decisions and your discharge might be delayed.
- **This power is very important.**

I. To communicate with health insurers about my care and treatment in order to arrange authorization and payment for services

- This power allows your agent to talk to and negotiate with your insurance providers so that your care can be paid for. Many insurance providers require authorization before care and treatment is provided, so your agent may need to negotiate with them before you can receive the care you need.

- Effect of limiting power: If you remove this power, your agent will not be able to negotiate payment for services and you may not get the care you need.
- **This power is very important; if your insurance company requires authorization before you can get necessary medical care, this power is extremely important.**

J. To take any necessary lawful actions to carry out these decisions, including granting releases of liability to medical providers

- This power allows your agent to sign consent forms for the treatment he has chosen for you. The other powers above allow your agent to make decisions; this power allows him or her to sign legal documents required before the care is actually given to you.
- Effect of limiting power: If you remove this power, your agent will not be able to sign medical releases which are required before any major treatment (such as surgery) is provided.
- **This power is extremely important.**

K. Choose one of the following options:

□ I do NOT authorize my agent to admit me to a facility for treatment of mental illness without my expressed informed consent.

□ To authorize my admission to a mental health facility as long as I DO NOT PROTEST the admission and other legal requirements are met.

□ To authorize my admission to a mental health facility even OVER MY PROTEST as long as other legal requirements are met. [Requires signature of physician or psychologist below.]

- Virginia law treats admission to a mental health facility differently than admission to other health care facilities. Giving your agent the authority to admit you to a hospital does not give your agent the authority to admit you to a psychiatric hospital or unit. There are three options here, each giving your agent a different degree of authority.

  - Option 1: gives your agent no authority to admit you to a mental health treatment facility unless you also consent. This is the default option if you do not choose Option 2 or 3. If you choose this option or choose no option, need mental health treatment, and you are incapable of giving consent for treatment, you may go through the legal process for involuntary commitment to a mental health facility.
  - Option 2: gives your agent the authority to admit you as long as you do not protest the admission even if you don't give consent.
  - Option 3: gives your agent the authority to admit you to a mental health facility for up to ten days **even over your objection** as long as:
    - ✓ I specifically give my agent this authority in my advance directive;
    - ✓ A licensed health care provider signs a statement in the advance directive that states that at the time I signed my advance directive giving my agent this authority: (a) I am capable of making an informed decision and; (b) I understand the consequences of giving my agent this power;

- ✓ A physician examines me and states in writing that (a) I have a mental illness; (b) I am incapable of making an informed decision about my admission; and (c) I need treatment in the facility

- Effect of limiting power: The agent's authority under each choice is described above. If you do not pick any option or leave this subsection out of your advance directive, the default is Option 1.
- **It is difficult to rate the importance of this power because it depends on the person and his or her experiences. For someone who does not have a mental health diagnosis and has never been treated in a mental health hospital, this power might be considered optional. For someone who has a mental health diagnosis but has never needed inpatient treatment, this power might be important to very important. For those individuals who have been hospitalized for mental health crises, this power might be very important. Consider each of the options carefully while also thinking about what your experience has been in the past. Remember, if you do not choose any of the options or you leave this subsection out of your advance directive, the default is option 1 and if you require inpatient mental health treatment, the admission will be through the involuntary commitment process.**

L. Additional powers, if any

This space allows you to add any powers that are not listed above.

11 You don't have to do anything with this paragraph. It simply states that the document will remain in effect throughout any times when you do not have capacity to make your own decisions. It also makes clear that you will continue to make your own decisions so long as you are able to do so and your agent only has the authority to make decisions for you when you cannot do so for yourself.

12 You don't have to do anything with this paragraph. It simply states that if you have ever written an advance directive before this one, the old one is no longer valid and everyone should now follow this one.

13 **Instructions v. preferences**

Some of the choices you state in your advance directive are instructions and some are preferences. Instructions are choices that must be followed except in very limited circumstances involving imminent danger of harm. For example, the powers you gave your agent above are instructions—they must be honored in every situation unless there is an emergency exception. A preference should be followed if possible. It's a fine distinction, but an important one. An example of a preference is the choice you make about the hospital where you want to be treated. That preference should be followed if that hospital provides the treatment you need and has a bed available, but if you need treatment that you cannot get at your chosen hospital or your chosen hospital is full, you will be taken to another facility. Each section will be identified as an instruction or preference when the distinction is relevant.

14 If you have a condition that can be treated either in a hospital or with assistance at home, you can state which setting you prefer. You can check this box if you prefer to be assisted at home. If you prefer to receive treatment in a hospital, you can cross through this section.
This is a preference.

15 If you do need inpatient treatment, you can state which hospital or hospitals you would choose to provide that care. If you don't have a preference, you can leave this section blank.
This is a preference.

16 If you have a definite desire to avoid one or more hospitals, you can state so here. It is a good idea, if possible, to state why you would choose not to go to a certain facility (for example, a bad previous experience).
This is a preference.

17 You can state which doctor or doctors you want involved in your treatment. This is a good place to provide information on your current health care providers. Although this says "treating physician(s), you can also include therapists or counselors who are not doctors (for example, a Licensed Clinical Social Worker or a Licensed Professional Counselor). Be sure to state the provider's specialty or area of practice.
This is a preference.

18 If you have a definite desire to avoid one or more doctors, you can state so here. It is a good idea, if possible, to state why you would choose not to be treated by a certain provider (for example, a bad previous experience).
This is a preference.

19 If you want your agent to make final decisions about medications when you do not have the capacity to make the decision, you can state so here by checking the box. If you check this box, your agent still must consider and follow your preferences and instructions you state in the next subsections if at all possible under the circumstances. Choosing this option would also allow your agent to make decisions about treatment for conditions you may not have considered or anticipated when you wrote your advance directive.
This is an instruction.

20 In this subsection, you can give consent now for medications you may need in the future. This consent is given while you have the capacity to do so in case you need the medication during a time of incapacity. If there is a medication that works well for you, this is a place to tell your doctor and agent that you want to take this medication if appropriate at the time. Include any special instructions about the medication (for example, if you know the medicine works for you at a certain dose but not at a higher dose, or if you need another medication to counteract the side effects of this medication, you would state that here).
This is a preference. It is a strong preference because you are giving your consent for medication and stating what works for you. However, it is a preference because even though you consent to it now, it may not be appropriate at the time you are incapacitated. Therefore, if you need to be treated for a certain condition, you are stating which medication you would prefer to take for that condition.

21 If you have one or more medications that you do not ever want to take, this is where you indicate that decision. If you have an allergy to a certain medication or you have had an adverse reaction to a medication, state so here. You can also include medications that you don't want to take because they caused side effects that outweighed the benefits of the drug or those that have been tried and didn't work for you. It is important to state the reason you do not want to take the medication. Doctors need to know immediately if you have an allergy or had a bad reaction to a

drug. It is also helpful for them to know if you've tried a medicine and based on that experience, you do not want to take it again.
This is an instruction. Just as you can refuse medications offered by your doctor today, you can refuse them now for a future time when you cannot voice this decision. There is an exception for emergency situations, defined as when there is an imminent danger that you will hurt yourself or someone else. In an emergency situation, your doctor may choose to give you a medication that you have listed here as a refusal if he decides that this is the only medication that will address the safety concern or it is the only option he has available. Your doctor should state the reason for this decision in your record and the medication should only be used until there is no longer a danger to you or others.

22 This is a place for you to add anything about your medications that has not been stated in the sections above. If you have a drug allergy, you can state there here even though you stated it above—it never hurts to repeat such important information. If you have one or more side effects you particularly want to avoid if at all possible, you can state so here (for example, if you are not willing to take a drug that causes nausea no matter how effective the drug may be, state so here). If you state the side effects you most want to avoid, doctors may be able to give you a different medication or add a medication to counteract side effects.

23 If you have a crisis plan in another document such as a WRAP (Wellness Recovery Action Plan), you can attach it to your advance directive and check this box to let your providers know to follow it as well as your advance directive. If you have a WRAP, you should not attach the entire plan. Simply attach the part of the plan that medical or psychiatric professionals may need to properly treat you. A crisis plan may include instructions for paying your bills or feeding your cat—your doctor does not need to know these things. By only including what is necessary for providers to know in a crisis, you are increasing the chance that your advance directive will be thoroughly read and followed. In other words, if you are in a crisis and need medical or psychiatric care, it's best if you keep the information as short and clear as possible so that providers do not have to read through a lot of information that is not relevant to your care.

24 This subsection gives you a space to tell your doctors and other treatment providers what things help calm you down if you are anxious or you are exhibiting behaviors that cause them to fear that you might hurt yourself or someone else. It also gives you a space to tell your providers what will make the situation worse.

- Things that help: Think about what you do for yourself when you feel anxious, scared, angry or out of control. Common examples include listening to music, reading, spending time alone, talking to a friend on the phone, or taking a walk. It is a good idea to include more than one option, if possible, because there may be a situation where you cannot use a coping mechanism you have stated (for example, if your provider is concerned that you might hurt yourself, you probably will not be allowed to spend time alone).
- Things that make the situation worse: If there are certain things that make your anxiety, fear or anger worse (often called "triggers'), it is important to let your doctor and other treating professionals know about it before you have such a reaction. We all have things that may trigger our fear, anxiety or anger. It may be things people do or say or a certain smell or sound. When we react to these things, it may not make sense to others around us because they are not affected by the same things. Use this space to identify those things that affect you and might cause you to have a strong reaction. Think about things that make you feel worse if you are already feeling anxious, scared or angry. Some common examples

include physical touch, a person's gender or size, being coerced to talk about it or being ignored, and being around too many people.

These are preferences.

25 Some facilities use seclusion and restraints when the provider decides that an individual is in danger of hurting himself or others. When someone is put in "seclusion", he is put in a room that he cannot leave and cannot have any interaction with others. A person in seclusion also has no access to his belongings or a telephone. Restraints are used to limit or prohibit movement of an individual. Such restraints may be physical (being held down by one or more people), mechanical (being held down by a device, such as straps, that the individual cannot remove), or chemical (using one or more medications to control a person's behavior). No one enjoys or wants any of these interventions, especially when they are already upset. These interventions may be particularly troubling if a person has experienced trauma that is relived whenever they are locked in a room alone or their movement is restrained. Some examples are being physically or sexually assaulted or being locked alone in a room as a child. If you have experienced such things that caused trauma to you back then and you will feel traumatized again by seclusion or restraint, you may check this box. You do not have to give any details about what happened to you or why you checked this box.

This is a preference, but it's a strong preference. Many hospitals and other facilities that offer medical and mental health care provide trauma-informed care (i.e. understanding, recognizing, and responding to the effects of trauma). Under trauma-informed care, providers must consider previous trauma and avoid re-traumatizing their patients.

26 Electroconvulsive therapy (ECT or commonly known as shock therapy) is a treatment option for people who experience certain mental health conditions. This treatment is often included in advance directives because it can be a controversial topic—people who know about ECT seem to either love it or hate it with very few people feeling neutral about it. If you have an opinion about it and whether you would want it considered for you at a time when you cannot voice the decision yourself, make such a decision known by checking one of the boxes. If it is something you consent to and authorize your agent to consent to, include any special instructions you might have (for example, only after a second opinion or only after talking to my primary care physician or psychiatrist).

The consent for ECT is a preference. The refusal of ECT is an instruction.

27 Your agent will be notified about your admission to a hospital or when you need treatment or assistance at any location and you do not have the capacity to make decisions for yourself. If there are others that you want to be notified, you can list them here along with their contact information. If you have several family members and friends you want to know about your admission to a hospital or your need for assistance, you should let your agent know but you do not need to list them all here. This space is for the most important people you feel need to know immediately, such as your primary care doctor, relevant specialist, psychiatrist or therapist. There are people you may tell your agent to notify in a separate document such as your employer, landlord, neighbors, friends or family.

This is a preference.

28 If you have any particular preferences about visitation when you are receiving inpatient care, you can state them here. You may have already stated that you want your agent to have the authority to make decisions about visitation in line 10(E) and you may just want to leave all such decisions to your agent. If so, check the first box. If you want anyone to be able to visit you with no

restrictions other than those imposed by the facility, check the second box. If you have more specific instructions about who may visit you, there are lines to state them here. Some people know that certain people upset them or cause too much drama and there may be someone who might be considered dangerous. State those people who you want prohibited from visiting you (some common examples are ex-spouses or partners, family or friends who create tension, a combination of people who create tension—if your aunt Diana does not get along with your uncle Charles, you can state that you do not want them to visit at the same time).
The decision to prohibit one or more visitors is an instruction. Allowing visitors is a preference.

29

You have had the opportunity to give preferences and instructions about many different health care topics. However, there may be something that is important to you that has not been covered in the sections above. This is where you can state those issues and how you want them handled. This is another good place to state any serious allergies you have (include medication and other allergies that cause a significant reaction requiring immediate medical attention; you do not need to include seasonal allergies such as pollen). If you have serious allergies to things other than medications, state them here; some examples include serious food allergies, serious reaction to latex or serious reaction to bee stings. If you carry epinephrine (commonly called an epipen) for an allergy, you should definitely include the allergy and the fact that you carry prescribed epinephrine.

30

If you wish to be an organ or tissue donor, you can state your decision here to make sure your agent and health care provider know. However, in order to make your decision legally binding, you must register as an organ donor either with the Division of Motor Vehicles (DMV) or with Donate Life Virginia. You can get more information at www.dmv.org/va-virginia/organ-donor.php or www.donatelifevirginia.org/
If you do NOT want to be an organ donor, check the second box and sign this section in the presence of two witnesses.

31

As defined on the form, a condition is terminal if your doctor has determined that your death is going to occur very soon and you will not recover even with medical treatment. Some examples include late-stage cancer or an injury that is not survivable. Your decisions about life-prolonging treatment stated here do NOT apply to situations where you may need such treatment for a limited period of time to recover from an illness or injury. There are two questions to consider under this subsection.

32

<u>Agent authority</u>

- You may want to give your agent the authority to make decisions about your end-of-life care using the choice you make in the next question as a guide to your general feelings about how to handle end-of-life decisions. If you choose this option, your agent must consider your preferences and values before making this decision. There are two common reasons people may choose this option: they don’t have strong feelings about end-of-life care because the issue is not before them at this moment or they want to give their agent the authority to make the decision at the time using all available information about the options and prognosis.
- You may choose to direct your agent and doctors to follow your instructions. Some people may choose this option if they have strong and definite feelings about end-of-life issues or they fear that their agent will not be able to follow their wishes when the time comes to do so.

33

Palliative Care, Extraordinary Care or Specific Instructions

- **Extraordinary care v. palliative care**: It is important to understand that there is no right or wrong answer because this very personal decision is based on your values and experience. Many people believe strongly one way or the other, but that decision is right for them, but not necessarily for others.
  - You may feel that if you are at the end of your life and there is no treatment that will provide a cure, you prefer to be kept as comfortable and pain-free as possible until you die naturally. This is called palliative care or comfort care. You can receive this type of care in a health care facility or at home. If you choose to spend your final days at home, you may want to contact a Hospice provider in your area. Hospice provides an array of services for individuals with a life-limiting illness, including care for the physical, emotional and spiritual needs of the patient as well as the family. Some people fear that if they choose this option, they will not get ANY care or treatment. This is not the case. You will receive treatment for symptom and pain relief regardless of which option you choose in this subsection.
  - You may want your life to be sustained using any treatment and devices available, including a ventilator, feeding tube, IV fluids and resuscitation efforts when your heart stops beating.
- **Specific instructions**: You may decide that neither option above is right for you. If so, you can write your own instructions for end-of-life care. One reason a person may choose this option is they may have different feelings about certain types of care. For example, a person may not want a ventilator but they do want a feeding tube. In that case, the person would choose this third option and would write out his instructions.

34

As stated in the form, persistent vegetative state is a condition that causes a person to be unaware of his surroundings and incapable of voluntary action or thought. It is important to recognize the difference between persistent vegetative state and similar conditions because your choice here only applies to persistent vegetative state, not the other diagnoses described below.

- **Persistent vegetative state**: The person may have sleep-awake cycles and may have involuntary movement, but they cannot purposefully move or interact with their environment or loved ones. The person also lacks cognition, meaning they cannot regain skills and knowledge they had before the illness or injury that caused their current condition. A person in this state can breathe on his own because that is an automatic bodily function, but he must receive nutrition and fluids through medical intervention because chewing and swallowing are not automatic bodily functions. A person can remain in this state for years if they receive artificial nutrition (i.e. feeding tube) and IV fluids to maintain their body.
- **Brain death**: There is irreversible cessation of all brain functions, including the brain stem. With no brain function, the person cannot sustain life without medical intervention including a ventilator to breathe. Unlike a person in a persistent vegetative state, a person who is brain dead cannot perform even automatic bodily functions such as breathing or responding to pain. A person generally does not live long in this state even with extraordinary care.
- **Coma**: A person in a coma is in a deep unconscious state from which he cannot be aroused even with pain. There is significantly decreased brain function and what function exists is very slow. The person is neither awake nor aware of his surroundings. A person may recover (wake up) within a few hours, days or weeks or he may remain in this state for a

longer time period. He may also partially wake up into a vegetative state or his brain may stop functioning to the point of brain death.

35 The choice about whether to give your agent the authority to make decisions based on your preferences or directing your agent and doctors to follow your stated wishes is the same as for end-of-life decisions in line 32.

36 The same three options you have for treatment and care at the end of life (Line 33) are also options here for persistent vegetative state.

37 There is an added option for care and treatment if you are in a persistent vegetative state: receive life-prolonging treatment for a specified period of time to allow for the possibility of improvement. If you choose this option, you need to specify how long you want to receive all possible treatments before making the decision to move from extraordinary care to palliative care. The amount of time varies from person to person. If you do not know what time period to specify, you should talk to your doctor and your close family and friends to help you determine a reasonable time period given your beliefs, values and experiences.

In both end-of-life and persistent vegetative state, if you are an organ donor and you choose not to receive extraordinary care or to stop it after a period of time, you will still receive the care needed to keep your body functioning until the organ donation process is complete.

38 Revocation means the cancellation of your advance directive, the withdrawal of power from your agent or both depending on your wishes. You can revoke your advance directive at any time, even if you lack the capacity to make medical decisions, as long as you recognize the consequences of doing so. You have another option available: make the decision now that you cannot revoke any part of your advance directive after two doctors have determined you lack capacity to make medical decisions. The reason some people choose this option is if they know or fear they will not make the best decisions for themselves when they are in a crisis and may not be thinking clearly. If you choose this option, after you are found to be incapacitated, your agent will have the authority to consent to treatment even if you object to it at the time. There are limitations to the agent's authority: your agent cannot withhold or discontinue life-prolonging care over your objection, you can specify specific limitations for certain decisions or conditions in the lines below, and your doctor must state that the treatment to be given over your objection is medically appropriate.

39 This box must be filled out and signed if you have given your agent the authority to make any decisions over your objection when you are incapacitated—the third option in line 10(J), admission to a mental health facility, or the second option in line 38, revocation only while you have capacity. If you have not chosen to give your agent this level of authority, you do not have to complete this section and can proceed to line 40.

If you have given your agent the authority to act over your objection, you must get the signature of a licensed treatment provider stating that you understand the decision you are making, the power you are giving your agent and the consequences of that decision. You should get this signature on or close to the same time you sign the advance directive.

The following treatment providers are permitted to sign this statement:

- Your attending physician;
- A licensed clinical psychologist;
- A licensed physician assistant;
- A licensed nurse practitioner;
- A licensed professional counselor; or
- A licensed clinical social worker

Signatures

40 You do not have to do anything with this statement. It just says that you have capacity to sign the advance directive.

41 Use this line to sign your advance directive once it is all complete and correct. Sign your full legal name and be sure to include the date on the line included for that purpose. Some people cannot sign their name and use a mark instead. That is fine because the witnesses below will see the person put his or her mark on the page as a signature.

42 Put your name on this line. You should put your name exactly as it appears on line 1.

43 These lines are for your witnesses to sign that they saw you sign the advance directive. They should sign their legal name and be sure to include the date on the line included for that purpose. The dates of the witnesses' signatures should match the date of your signature because you must sign the document in front of each other. The witnesses do not have to know you. They are simply witnessing that you are signing the advance directive voluntarily.

Note on notary: Virginia law does not require an advance directive to be notarized, but it is a good idea if possible. If you decide to get it notarized, the notary's statement and seal would appear here under the signatures. If you use a notary, you and your witnesses must sign the document in front of the notary and all of the dates must match. You will be required to present identification to the notary because he must verify that you are the correct person signing the paper.

VIRGINIA ADVANCE HEALTH CARE DIRECTIVE

I, _____ 1 _____, (born on: _____ 2 _____) willfully and voluntarily write this health care advance directive to assure that, during periods of incapacity, my choices for health care will be carried out even when I am not able to make informed decisions on my own behalf.

Appointment of Agent

[*Cross through this section if you do not want to name an agent to make health decisions for you when you cannot do so*.]

I appoint the following agents, in order of priority, to make health care decisions for me as authorized in this document:

1. Name: 3 _____

Address: 4 _____

Phone Numbers: 5 _____

2. Name: 6 _____

Address: _____

Phone Numbers: _____

3. Name: _____

Address: _____

Phone Numbers: _____

4. Name: _____

Address: _____

Phone Numbers: _____

7 ☐ I have additional alternate agents listed on a separate page.

8 I grant to my agent full power and authority to make health care decisions for me as described below whenever I am incapable of making an informed decision. Before my agent has any authority to make decisions for me, there must be a written determination of capacity as required by law. If any physician examines me and decides that I have the ability to make my own decisions, all further health care decisions will require my informed consent.

9 In making health care decisions for me, my agent shall follow my wishes and preferences as stated here or as otherwise known. If my agent cannot determine what health care choice I would make for myself, then and only then, he or she must make the choice based on what he or she believes to be in my best interests.

10 Agent Powers

[*Cross through any powers listed below that you do not want to give your agent, but keep in mind that any power you take away from your agent may affect his or her ability to make informed decisions about your care.*]

I give my agent the power:

A. To provide or refuse consent to any type of medical treatment, medication and procedures.
B. To make decisions about life-prolonging treatment (following any instructions or guidance below).
C. To request, receive, and review any information, oral or written, about my health care and to consent to the disclosure of this information. I intend that this grant of authority shall meet the requirements of HIPAA and that my agent shall have full access and authority over my medical information.
D. To hire and fire my health care providers.
E. To make decisions regarding visitation consistent with any wishes known by my agent during any time that I am admitted to any health care facility.
F. To authorize my participation in any health care study approved according to applicable federal or state law that offers the prospect of direct therapeutic benefit to me.
G. To authorize my participation in any health care study approved according to applicable federal or state law that aims to increase scientific understanding or to promote human well-being, even though it offers no prospect of direct benefit to me.
H. To authorize my admission to or discharge from any hospital, hospice, nursing home or other medical care facility, not including a mental health facility.
I. To communicate with health insurers about my care and treatment in order to arrange authorization and payment for services.
J. To take any necessary lawful actions to carry out these decisions, including granting releases of liability to medical providers.
K. Choose <u>one</u> of the following options:

☐ I do **NOT** authorize my agent to admit me to a facility for treatment of mental illness without my expressed informed consent.

☐ To authorize my admission to a mental health facility as long as **I DO NOT PROTEST** the admission and other legal requirements are met.

☐ To authorize my admission to a mental health facility even **OVER MY PROTEST** as long as other legal requirements are met. [*Requires signature of physician or psychologist below*.]

L. Additional powers, if any: _____

_____

11 This is a durable power of attorney and shall not terminate upon my incapacity. This power exists only as to those health care decisions for which I am unable to give informed consent.

12 Prior Designations Revoked: I revoke any prior Healthcare Power of Attorney.

13 **My Instructions and Desires for Health Treatment and Care**

[If you wish to leave certain decisions to your agent, simply cross through that section.]

14 ☐ Preference for outpatient care: If my condition is serious enough to require 24-hour care and I have no physical conditions that require immediate access to emergency medical care, I would prefer to receive this care at home or in programs designed as alternatives to hospitalization.

15 If I am to be admitted to a hospital for 24-hour care, I would prefer to go to the following hospitals:

_____

_____

16 I do ***not*** wish to be admitted to the following hospitals or programs for the reasons I have listed:

_____ _____
Facility Reason

_____ _____
Facility Reason

17 **My Preferences About Physicians**

My choice of treating physician(s):

1. Name: _____

Address: _____

Phone Number: _____ Specialty: _____

2. Name: _____

Address: _____

Phone Number: _____ Specialty: _____

3. Name: _____

Address: _____

Phone Number: _____ Specialty: _____

18 I do not wish to be treated by the following physicians, for the reasons stated:

Dr. _____ Reason: _____

Dr. _____ Reason: _____

My Preferences Regarding Medications

19 ☐ I consent to the medications agreed to by my agent, after consultation with my treating physician, with any reservations described below.

20 **My Medication Preferences** I consent to and authorize my agent to consent to:

Medication: _____
Special Instructions: _____

Medication: _____
Special Instructions: _____

Medication: _____
Special Instructions: _____

21 **My Medication Refusals** I do NOT consent to and my agent does not have the authority to consent to the following medications (or their brand-name, trade-name, or generic equivalents):

Medication or type of medication: _____
Reason I refuse this medication: _____

Medication or type of medication: _____
Reason I refuse this medication: _____

Medication or type of medication: _____
Reason I refuse this medication: _____

22 Additional preferences about medication: [include side effects you most want to avoid and any other instructions about medications.] _____
_____

My Preferences for Emergency Intervention

23 ☐ I have a crisis intervention plan attached to this document and I ask that it be followed in times of crisis.

24 When I am in a crisis and in danger of hurting myself or someone else, these things help calm me down: _____
_____
_____

When I am in a crisis and in danger of hurting myself or someone else, these things make the situation worse: _____

_____

_____

25 ☐ I have experienced a traumatic experience in my past that makes seclusion and restraint particularly stressful and thus inappropriate for me.

Electroconvulsive Therapy (ECT) Instructions

26 If it is determined that I am not legally capable of consenting to or refusing electroconvulsive therapy, my wishes are as follows:

☐ I do ***not*** consent to administration of ECT.
---------- OR----------
☐ I consent, and authorize my agent to consent, to the administration of ECT.

Special instructions and wishes about ECT: _____

_____

_____

My Preferences Regarding Notification of Others and Visitation

27 In addition to my agent(s), please notify the following people:

Name: _____ Relationship: _____

Home: _____; Cell: _____; Other: _____

Name: _____ Relationship: _____

Home: _____; Cell: _____; Other: _____

Name: _____ Relationship: _____

Home: _____; Cell: _____; Other: _____

28 ☐ My agent has the authority over who may visit me.
----OR----
☐ I prefer open visitation with no restrictions.

Special Instructions about Visitation:_____

_____

29 **Other instructions about health care:**

_____

_____

_____

_____

Anatomical Gift; Organ, Tissue or Eye Donation

30 ☐ Upon my death, I wish to be an organ and tissue donor. I direct that an anatomical gift of all of my body or certain organ, tissue or eye donations be made in accordance with my directions, if any. My agent shall have the authority to sign any authorization necessary to carry out these wishes. If I do not have an agent, please let this document suffice as authorization to carry out my wishes.

Special instructions about organ, tissue or eye donation: _____

_____

☐ I do NOT want to be an organ donor and I do NOT authorize my agent or family to consent to the donation of my organs or tissues.

_____ _____
Signature Date

_____ _____
Witness Date

_____ _____
Witness Date

Life-Prolonging Treatment

31 **Terminal Condition**: If my doctor determines that my death is imminent (very soon) and it is reasonably certain that I will not recover even with medical treatment, I direct the following: [*choose one option below*]

32 ☐ I want my Agent to make all decisions about life-prolonging treatment based on my preferences chosen below and what he or she knows to be my beliefs and values.
----------OR----------
☐ I direct my agent (if I have appointed one), family and physicians to follow my wishes as written below.

33 [*choose one option below*]

☐ I do not want any treatments to prolong my life. I understand that I 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.

----------OR----------

☐ My own instructions: *[If you have preferences about tube feeding, IV fluids, cardiopulmonary resuscitation (CPR), and ventilator (breathing machine), put them here.]*

_____

_____

_____

34 **Persistent vegetative state**: If my doctor determines that I am in a permanent state of unawareness in which I have no voluntary action or thought, I cannot interact with others and it is reasonably certain that I will never recover this awareness or ability even with medical treatment, I direct the following: [choose one option below]

35 ☐ I want my Agent to make all decisions about life-prolonging treatment based on my preferences chosen below and what he or she knows to be my beliefs and values.

----------OR----------

☐ I direct my agent (if I have appointed one), family and physicians to follow my wishes as written below.

[*choose one option below*]

36 ☐ I do not want any treatments to prolong my life. I understand that I 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.

----------OR----------

37 ☐ 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. I understand that I still will receive treatment to relieve pain and make me comfortable.

----------OR----------

☐ My own instructions: *[If you have preferences about tube feeding, IV fluids, cardiopulmonary resuscitation (CPR), and ventilator (breathing machine), put them here.]*

_____

_____

_____

If I have indicated in any way that I wish to be an organ, eye, or tissue donor, I authorize the use of life prolonging procedures for the specific purpose of ensuring that these organs are medically suitable for donation.

38 **Revocation and Objection:** [choose one option below]

☐ Even if I am incapable of making an informed decision, I still want to be able to protest my agent's authority to the extent allowed by law.

☐ If I am incapable of making an informed decision, I want my agent to continue to serve and have the power to authorize health care that is permitted by law and consistent with my beliefs, values and preferences even if I object. If I have not named an agent, I wish that these instructions be followed even over my objection during times when I am incapable of giving consent to health care treatment.

Special instructions or limitations on agent's power to authorize treatment over my objection: _____

39 **Treatment or Admission over Objection—Attestation of Capacity**: If I give my agent the power to consent to any health care treatment or admission to a mental health facility over my objection, a licensed health care provider must state that I understand the effect of that decision by signing the statement below. The following treatment providers may sign this statement: an attending licensed physician, a licensed clinical psychologist, a licensed physician assistant, a licensed nurse practitioner, a licensed professional counselor, or a licensed clinical social worker.

My physician or licensed clinical psychologist attests that I am capable of making an informed decision and that I understand the consequences of this provision of my advance directive:

_____ _____

Signature of licensed treatment provider Date

_____ _____

Printed name of licensed treatment provider Phone number

Signatures

40 AFFIRMATION: I am mentally capable of making this advance directive and I understand its purpose and effect.

41 _____ _____

Signature Date

42 I attest that _____ voluntarily signed this advance directive in my presence.

43 _____ _____

Witness Date

_____ _____

Witness Date

VIRGINIA ADVANCE HEALTH CARE DIRECTIVE

I, _____, (born on: _____) willfully and voluntarily write this health care advance directive to assure that, during periods of incapacity, my choices for health care will be carried out even when I am not able to make informed decisions on my own behalf.

Appointment of Agent

[*Cross through this section if you do not want to name an agent to make health decisions for you when you cannot do so*.]

I appoint the following agents, in order of priority, to make health care decisions for me as authorized in this document:

1. Name: _____

Address: _____

Phone Numbers: _____

2. Name: _____

Address: _____

Phone Numbers: _____

3. Name: _____

Address: _____

Phone Numbers: _____

4. Name: _____

Address: _____

Phone Numbers: _____

☐ I have additional alternate agents listed on a separate page.

I grant to my agent full power and authority to make health care decisions for me as described below whenever I am incapable of making an informed decision. Before my agent has any authority to make decisions for me, there must be a written determination of capacity as required by law. If any physician examines me and decides that I have the ability to make my own decisions, all further health care decisions will require my informed consent.

In making health care decisions for me, my agent shall follow my wishes and preferences as stated here or as otherwise known. If my agent cannot determine what health care choice I would make for myself, then and only then, he or she must make the choice based on what he or she believes to be in my best interests.

Agent Powers

[*Cross through any powers listed below that you do not want to give your agent, but keep in mind that any power you take away from your agent may affect his or her ability to make informed decisions about your care.*]

I give my agent the power:

A. To provide or refuse consent to any type of medical treatment, medication and procedures.
B. To make decisions about life-prolonging treatment (following any instructions or guidance below).
C. To request, receive, and review any information, oral or written, about my health care and to consent to the disclosure of this information. I intend that this grant of authority shall meet the requirements of HIPAA and that my agent shall have full access and authority over my medical information.
D. To hire and fire my health care providers.
E. To make decisions regarding visitation consistent with any wishes known by my agent during any time that I am admitted to any health care facility.
F. To authorize my participation in any health care study approved according to applicable federal or state law that offers the prospect of direct therapeutic benefit to me.
G. To authorize my participation in any health care study approved according to applicable federal or state law that aims to increase scientific understanding or to promote human well-being, even though it offers no prospect of direct benefit to me.
H. To authorize my admission to or discharge from any hospital, hospice, nursing home or other medical care facility, not including a mental health facility.
I. To communicate with health insurers about my care and treatment in order to arrange authorization and payment for services.
J. To take any necessary lawful actions to carry out these decisions, including granting releases of liability to medical providers.
K. Choose <u>one</u> of the following options:

☐ I do **NOT** authorize my agent to admit me to a facility for treatment of mental illness without my expressed informed consent.

☐ To authorize my admission to a mental health facility as long as **I DO NOT PROTEST** the admission and other legal requirements are met.

☐ To authorize my admission to a mental health facility even **OVER MY PROTEST** as long as other legal requirements are met. [*Requires signature of physician or psychologist below*.]

L. Additional powers, if any: _____
_____

This is a durable power of attorney and shall not terminate upon my incapacity. This power exists only as to those health care decisions for which I am unable to give informed consent.

Prior Designations Revoked: I revoke any prior Healthcare Power of Attorney.

My Instructions and Desires for Health Treatment and Care

[If you wish to leave certain decisions to your agent, simply cross through that section.]

☐ Preference for outpatient care: If my condition is serious enough to require 24-hour care and I have no physical conditions that require immediate access to emergency medical care, I would prefer to receive this care at home or in programs designed as alternatives to hospitalization.

If I am to be admitted to a hospital for 24-hour care, I would prefer to go to the following hospitals:

_____

_____

I do ***not*** wish to be admitted to the following hospitals or programs for the reasons I have listed:

Facility	Reason
Facility	Reason

My Preferences About Physicians

My choice of treating physician(s):

1. Name: _____

Address: _____

Phone Number: _____ Specialty: _____

2. Name: _____

Address: _____

Phone Number: _____ Specialty: _____

3. Name: _____

Address: _____

Phone Number: _____ Specialty: _____

I do not wish to be treated by the following physicians, for the reasons stated:

Dr. _____ Reason: _____

Dr. _____ Reason: _____

My Preferences Regarding Medications

☐ I consent to the medications agreed to by my agent, after consultation with my treating physician, with any reservations described below.

My Medication Preferences I consent to and authorize my agent to consent to:

Medication: _____
Special Instructions: _____

Medication: _____
Special Instructions: _____

Medication: _____
Special Instructions: _____

My Medication Refusals I do NOT consent to and my agent does not have the authority to consent to the following medications (or their brand-name, trade-name, or generic equivalents):

Medication or type of medication: _____
Reason I refuse this medication: _____

Medication or type of medication: _____
Reason I refuse this medication: _____

Medication or type of medication: _____
Reason I refuse this medication: _____

Additional preferences about medication: [include side effects you most want to avoid and any other instructions about medications.] _____
_____

My Preferences for Emergency Intervention

☐ I have a crisis intervention plan attached to this document and I ask that it be followed in times of crisis.

When I am in a crisis and in danger of hurting myself or someone else, these things help calm me down: _____
_____
_____

When I am in a crisis and in danger of hurting myself or someone else, these things make the situation worse: _____

_____

_____

☐ I have experienced a traumatic experience in my past that makes seclusion and restraint particularly stressful and thus inappropriate for me.

Electroconvulsive Therapy (ECT) Instructions

If it is determined that I am not legally capable of consenting to or refusing electroconvulsive therapy, my wishes are as follows:

☐ I do ***not*** consent to administration of ECT.
---------- OR----------
☐ I consent, and authorize my agent to consent, to the administration of ECT.

Special instructions and wishes about ECT: _____

_____

_____

My Preferences Regarding Notification of Others and Visitation

In addition to my agent(s), please notify the following people:

Name: _____ Relationship: _____

Home: _____; Cell: _____; Other: _____

Name: _____ Relationship: _____

Home: _____; Cell: _____; Other: _____

Name: _____ Relationship: _____

Home: _____; Cell: _____; Other: _____

☐ My agent has the authority over who may visit me.
----OR----
☐ I prefer open visitation with no restrictions.

Special Instructions about Visitation: _____

_____

Other instructions about health care:

_____

_____

_____

_____

Anatomical Gift; Organ, Tissue or Eye Donation

□ Upon my death, I wish to be an organ and tissue donor. I direct that an anatomical gift of all of my body or certain organ, tissue or eye donations be made in accordance with my directions, if any. My agent shall have the authority to sign any authorization necessary to carry out these wishes. If I do not have an agent, please let this document suffice as authorization to carry out my wishes.

Special instructions about organ, tissue or eye donation: _____

_____

□ I do NOT want to be an organ donor and I do NOT authorize my agent or family to consent to the donation of my organs or tissues.

_____ _____
Signature Date

_____ _____
Witness Date

_____ _____
Witness Date

Life-Prolonging Treatment

Terminal Condition: If my doctor determines that my death is imminent (very soon) and it is reasonably certain that I will not recover even with medical treatment, I direct the following: [*choose one option below*]

☐ I want my Agent to make all decisions about life-prolonging treatment based on my preferences chosen below and what he or she knows to be my beliefs and values.

----------OR----------

☐ I direct my agent (if I have appointed one), family and physicians to follow my wishes as written below.

[*choose one option below*]

☐ I do not want any treatments to prolong my life. I understand that I 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.

----------OR----------

☐ My own instructions: *[If you have preferences about tube feeding, IV fluids, cardiopulmonary resuscitation (CPR), and ventilator (breathing machine), put them here.]*

_____

_____

_____

Persistent vegetative state: If my doctor determines that I am in a permanent state of unawareness in which I have no voluntary action or thought, I cannot interact with others and it is reasonably certain that I will never recover this awareness or ability even with medical treatment, I direct the following: [choose one option below]

☐ I want my Agent to make all decisions about life-prolonging treatment based on my preferences chosen below and what he or she knows to be my beliefs and values.

----------OR----------

☐ I direct my agent (if I have appointed one), family and physicians to follow my wishes as written below.

[*choose one option below*]

☐ I do not want any treatments to prolong my life. I understand that I 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.

----------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. I understand that I still will receive treatment to relieve pain and make me comfortable.

----------OR----------

☐ My own instructions: *[If you have preferences about tube feeding, IV fluids, cardiopulmonary resuscitation (CPR), and ventilator (breathing machine), put them here.]*

_____

_____

_____

If I have indicated in any way that I wish to be an organ, eye, or tissue donor, I authorize the use of life prolonging procedures for the specific purpose of ensuring that these organs are medically suitable for donation.

Revocation and Objection:

[choose one option below]

☐ Even if I am incapable of making an informed decision, I still want to be able to protest my agent's authority to the extent allowed by law.

☐ If I am incapable of making an informed decision, I want my agent to continue to serve and have the power to authorize health care that is permitted by law and consistent with my beliefs, values and preferences even if I object. If I have not named an agent, I wish that these instructions be followed even over my objection during times when I am incapable of giving consent to health care treatment.

Special instructions or limitations on agent's power to authorize treatment over my objection: _____

Treatment or Admission over Objection—Attestation of Capacity: If I give my agent the power to consent to any health care treatment or admission to a mental health facility over my objection, a licensed health care provider must state that I understand the effect of that decision by signing the statement below. The following treatment providers may sign this statement: an attending licensed physician, a licensed clinical psychologist, a licensed physician assistant, a licensed nurse practitioner, a licensed professional counselor, or a licensed clinical social worker.

My physician or licensed clinical psychologist attests that I am capable of making an informed decision and that I understand the consequences of this provision of my advance directive:

_____ _____
Signature of licensed treatment provider Date

_____ _____
Printed name of licensed treatment provider Phone number

Signatures

AFFIRMATION: I am mentally capable of making this advance directive and I understand its purpose and effect.

_____ _____
Signature Date

I attest that _____ voluntarily signed this advance directive in my presence.

_____ _____
Witness Date

_____ _____
Witness Date