VIRGINIA ADVANCE HEALTH CARE DIRECTIVE

I, _____, (DOB:) 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: _____

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

K. 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.]

☐ <u>Preference for outpatient care</u>: 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 <u>hospital</u> 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
_____	_____
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: _____

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: _____
_____
_____

And these things will make the situation worse: _____
_____
_____

(Address the following, if applicable: seclusion, physical restraints, seclusion and restraints, medication by injection, medication by pill or liquid)

☐ 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: _____

☐ 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

[*Cross out if you do not want to be an organ donor*.]

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. If I need to receive life-prolonging treatment until my organs can be removed for transplantation, I consent to such treatment for that limited period of time.

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: _____
_____
_____

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/respirator (breathing machine), put them here.]* _____

_____

_____

Permanent 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/respirator (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 physician or a licensed psychologist must state that I understand the effect of that decision by signing the statement below.

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 physician or psychologist Date

_____ _____
Printed name of physician or psychologist 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