VIRGINIA ADVANCE DIRECTIVE FOR HEALTH CARE

I, _____
Printed Name of Individual Making This Advance Health Care Directive (Declarant)

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

YOU MAY INCLUDE ANY OR ALL OF SECTIONS I AND II BELOW.

SECTION I: APPOINTMENT AND POWERS OF MY AGENT

CROSS THROUGH THIS SECTION IF YOU DO NOT WANT TO APPOINT AN AGENT TO MAKE HEALTH CARE DECISIONS FOR YOU.

A. APPOINTMENT OF MY AGENT

I hereby appoint: _____
Name of Primary Agent E-mail Address

_____
Home Address Telephone Number

as my agent to make health care decisions on my behalf as authorized in this document.

If the primary agent named above is not reasonably available or is unable or unwilling to act as my agent, then I appoint as successor agent to serve in that capacity:

_____
Name of Successor Agent E-mail Address

_____
Home Address Telephone Number

I grant to my agent full authority to make health care decisions on my behalf as described below. My agent shall have this authority whenever and for as long as I have been determined to be incapable of making an informed decision.

In making health care decisions on my behalf, I want my agent to follow my desires and preferences as stated in this document or as otherwise known to him or her. 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.

B. POWERS OF MY AGENT

IF YOU APPOINTED AN AGENT ABOVE, YOU MAY GIVE HIM/HER THE POWERS SUGGESTED BELOW. YOU MAY CROSS THROUGH ANY POWERS YOU DO NOT WANT TO GIVE YOUR AGENT AND ADD ADDITIONAL POWERS YOU DO WANT TO GIVE YOUR AGENT.

The powers of my agent shall include the following:

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 excess of recommended dosages in an amount sufficient to relieve pain. This applies even if this medication carries the risk of addiction or of inadvertently hastening my death;

2. To request, receive and review any oral or written information regarding my physical or mental health, including but not limited to medical and hospital records, and to consent to the disclosure of this information as necessary to carry out my directions as stated in this advance directive;

3. To employ and 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, consistent with the following directions:

_____;

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.

11. To donate all or part of my body for transplantation, therapy, research or education.

ADDITIONAL POWERS, IF ANY:_____

_____

SECTION II: MY HEALTH CARE INSTRUCTIONS

YOU MAY USE ANY OR ALL OF PARTS 1, 2 OR 3 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.

1. 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:

CHECK ONLY 1 BOX IN THIS PART 1.

☐ 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)*

☐ *YOU MAY WRITE HERE YOUR OWN INSTRUCTIONS ABOUT YOUR CARE WHEN YOU ARE DYING, INCLUDING SPECIFIC INSTRUCTIONS ABOUT TREATMENTS THAT YOU* ***DO WANT****, IF MEDICALLY APPROPRIATE, OR* ***DON'T WANT****. IT IS IMPORTANT THAT YOUR INSTRUCTIONS HERE DO NOT CONFLICT WITH OTHER INSTRUCTIONS YOU GIVE IN THIS ADVANCE DIRECTIVE*:

_____

_____

2. I provide the following instructions if 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 ability even with medical treatment:

CHECK ONLY 1 BOX IN THIS PART 2.

☐ 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)*

☐ *YOU MAY WRITE HERE YOUR INSTRUCTIONS ABOUT YOUR CARE WHEN YOU ARE UNABLE TO INTERACT WITH OTHERS AND ARE NOT EXPECTED TO RECOVER THIS ABILITY. THIS INCLUDES SPECIFIC INSTRUCTIONS ABOUT TREATMENTS YOU **DO WANT**, IF MEDICALLY APPROPRIATE, OR **DON'T WANT**. IT IS IMPORTANT YOUR INSTRUCTIONS HERE DO NOT CONFLICT WITH OTHER INSTRUCTIONS YOU GIVE IN THIS ADVANCE DIRECTIVE.*

_____

_____

3. I provide the following other instructions concerning my health care:

*YOU MAY WRITE HERE 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 GIVE IN THIS ADVANCE DIRECTIVE.*

_____

_____

AFFIRMATION AND RIGHT TO REVOKE: By signing below, I indicate that I understand this document and that I am willingly and voluntarily executing it. I also understand that I may revoke all or any part of it at any time as provided by law.

_____ _____

(Date) (Signature of Declarant)

The declarant signed the foregoing advance directive in my presence. *TWO ADULT WITNESSES NEEDED.*

1) _____ _____

Witness Signature Witness Name Printed

2) _____ _____

Witness Signature Witness Name Printed

This form satisfies the requirements of Virginia's Health Care Decisions Act. If you have legal questions about this form or would like to develop a different form to meet your particular needs, you should talk with an attorney. It is your responsibility to provide a copy of your advance medical directive to your treating physician. You also should provide copies to your agent, close relatives and/or friends. This form is provided by Carilion Clinic as a service to its patients and the public.