As You Wish ADVANCE CARE PLANNING

Virginia Advance Directive for Health Care

I, _____, willingly and voluntarily state my
Printed Name of Individual making this Advance Directive for Healthcare (Declarant)
wishes in the event I am incapable of making an informed decision about my health care as follows:

SECTION I - APPOINTMENT AND POWERS OF MY AGENT

Cross through this Section I 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:_____
Name of Primary Agent
Address: _____City: _____St:____Zip: _____
Phone: _____Cell: _____Email: _____

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 the following as successor agent to serve in that capacity:

Name:_____
Name of Successor Agent
Address: _____City: _____St:____Zip: _____
Phone: _____Cell: _____Email: _____

I grant 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 - The powers of my agent shall include the following:

You may cross through any powers listed below that you do not want to give to your agent and add any additional powers you do want to give your agent.

1. To consent to or refuse or withdraw consent to any type of health care, including, but not limited to, artificial respiration (breathing machine), artificially administered nutrition (tube feeding) and hydration (IV fluids), and cardiopulmonary resuscitation (CPR). This authorization specifically includes the power to consent to dosages of pain-relieving medication in 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 grant any lawful actions that may be necessary to carry out these decisions, including the granting or release of liability to medical providers.

ADDITIONAL POWERS OR LIMITATIONS, IF ANY:

_____
_____
_____
_____

SECTION II - MY HEALTH CARE INSTRUCTIONS

You many use any or all Parts 1 and 2 of this Section or Section 3 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. If death is imminent: 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.

[**Initial Only One Selection Below**. Use the space provided at the end of Question 1 to add any instructions to your selection of A, B, or C where you have written your initials.]

____ **A.** 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)

____ **B.** 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)

____ **C.** My instructions for treatment follow: (Write your own instructions here about 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 have given in this advance directive.)

2. **If I am permanently unconscious**: 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:

[**Initial Only One Selection Below**. Use the space provided at the end of Question 2 to add any instructions to your selection of A, B, C or D where you have written your initials.]

____ **A.** 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)

____ **B.** 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)

____ **C.** I want to try treatments for a period of time in the hope of some improvement of my condition. I suggest _____ as a 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)

____ **D.** My instructions for treatment follow. (Write your own instructions here about care when you are unable to interact with others and not expected to recover this ability. This includes 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 have given in this advance directive.)

SECTION III - ANATOMICAL GIFTS

You may use this document to record your decision to donate your organs, eyes, and tissues or your whole body after your death. If you do not make this decision here or in any other document, your agent can make the decision for you unless you specifically prohibit him/her from doing so, which you may do in this or some other document. Check one of the boxes below if you wish to use this section to make your donation decision.

[ ] I donate my organs, eyes and tissues for use in transplantation, therapy, research and education. I direct that all necessary measures be taken to ensure the medical suitability of my organs, eyes or tissues for donation. I understand that I may register my directions at the department of Motor Vehicles or directly on the donor registry, www.DonateLifeVirginia.org, and that I may use the donor registry to amend or revoke my directions; OR

[ ] I donate my whole body for research and education.

Write any specific instructions you wish to give about anatomical gifts here:

_____

_____

_____

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)**

_____ _____

Witness Signature ***Witness Printed***

_____ _____

Witness Signature ***Witness 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 preferences, you should contact an attorney. This form is provided by the Advance Care Planning Coalition of Eastern Virginia serving the community through the As You Wish Advance Care Planning program.

Declarant Identification for Health Provider Filing: ___ / ___ / _____ ___ ___ ___ ___

Date of Birth (MM/DD/YYYY) *Last 4 digits of Social Security Number*

As You Wish

ADVANCE CARE PLANNING

A program of the Advance Care Planning Coalition of Eastern Virginia

www.asyouwishvirginia.org