## Virginia Advance Directive

PRINT YOUR NAME

I, _____,
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 in this document.

This advance directive shall not terminate in the event of my disability.

## PART I: APPOINTMENT OF AGENT

(CROSS THROUGH AND INITIAL IF YOU DO NOT WANT TO APPOINT AN AGENT TO MAKE HEALTH CARE DECISIONS FOR YOU)

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR PRIMARY AGENT

I hereby appoint _____,
(primary agent)
of _____

_____
(address and telephone number)

as my agent to make health care decisions on my behalf as authorized in this document. If the person I have appointed above is not reasonably available or is unable or unwilling to act as my agent, then I appoint

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR ALTERNATE AGENT

_____,
(alternate agent)
of _____

_____,
(address and telephone number)
to serve in that capacity.

I grant to my agent, named above, full power and authority to make health care decisions on my behalf, as described below, whenever I have been determined to be incapable of making an informed decision. My agent's authority hereunder is effective as long as I am 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.

**POWERS OF MY AGENT**
(CROSS THROUGH AND INITIAL ANY LANGUAGE YOU DO NOT WANT AND ADD ANY LANGUAGE YOU DO WANT)

POWERS OF YOUR AGENT

CROSS THROUGH AND INITIAL ANY LANGUAGE YOU DO NOT WANT AND ADD ANY LANGUAGE YOU DO WANT

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.

POWERS OF YOUR AGENT (continued)

9. To make decisions regarding visitation during any time that I am admitted to any health care facility, consistent with the following directions:_____

PRINT ANY ADDITIONAL POWERS YOU WANT YOUR AGENT TO HAVE OR ANY LIMITATIONS ON THE POWERS OF YOUR AGENT, IF ANY

11. Additional powers or limitations, if any:

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

I give the following instructions to further guide my agent in making health care decisions for me:

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

(attach additional pages if needed)

## PART II: HEALTH CARE INSTRUCTIONS

[YOU MAY USE ANY OR ALL OF PARTS A, B, OR C 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. IF YOU ARE AN ORGAN, EYE OR TISSUE DONOR, YOUR INSTRUCTIONS WILL BE APPLIED SO AS TO ENSURE THE MEDICAL SUITABILITY OF YOUR ORGANS, EYES AND TISSUES FOR DONATION.]

### A. Instructions If I have a Terminal Condition

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

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 HAVE GIVEN IN THIS ADVANCE DIRECTIVE

ATTACH ADDITIONAL PAGES IF NEEDED



____ 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 direct the following regarding health care when I am dying:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

(attach additional pages if needed)

INITIAL ONLY ONE

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 THAT YOUR INSTRUCTIONS HERE DO NOT CONFLICT WITH OTHER INSTRUCTIONS YOU HAVE GIVEN IN THIS ADVANCE DIRECTIVE

ATTACH ADDITIONAL PAGES IF NEEDED



## B. Instructions if I am in a Persistent Vegetative State

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:

____ 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 _____ (insert time period) as the period of time, after which such treatment should be stopped if my condition has not improved. The exact time period is at the discretion of my agent or surrogate in consultation with my physician. I understand that I still will receive treatment to relieve pain and make me comfortable.

OR

____I direct the following regarding when I am 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:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

(attach additional pages if needed)

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 HAVE GIVEN IN THIS ADVANCE DIRECTIVE

THESE INSTRUCTIONS CAN ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED



## C. Other Instructions Regarding My Health Care

I further direct the following regarding my health care when I am incapable of making my own health care decisions:

(attach additional pages if needed)

## PART III: ORGAN DONATION

[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.]

IF YOU WISH TO DONATE YOUR ORGANS, EYES, OR TISSUES, INITIAL THE OPTION THAT REFLECTS YOUR WISHES

_____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.

INSERT ANY SPECIFIC INSTRUCTIONS YOU WISH TO GIVE ABOUT ANATOMICAL GIFTS, IF ANY

ATTACH ADDITIONAL PAGES IF NECESSARY

I direct the following regarding donation of my organs, eyes, and tissues:

## PART IV: EXECUTION

**Affirmation and Right to Revoke:** By signing below, I indicate that I am emotionally and mentally capable of making this advance directive and that I understand the purpose and effect of this document. I understand I may revoke all or any part of this document at any time.

SIGN, DATE, AND PRINT YOUR NAME HERE

_____

(signature of declarant) (date)

_____

(printed name)

The declarant signed the foregoing advance directive in my presence.

YOUR TWO WITNESSES MUST SIGN, DATE, AND PRINT THEIR NAMES HERE

Witness Signature _____ Date_____

Printed name _____

Witness Signature _____ Date_____

Printed name _____



*Courtesy of Caring Info*
*1731 King St., Suite 100, Alexandria, VA 22314*
*www.caringinfo.org, 800/658-8898*