

VIRGINIA
Advance Directive
Planning for Important Healthcare Decisions

Caring Connections
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CARING CONNECTIONS

Caring Connections, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

Caring Connections tracks and monitors all state and federal legislation and significant court cases related to end-of-life care to ensure that our advance directives are up to date.

It's About How You LIVE

It's About How You LIVE is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

- L**earn about options for end-of-life services and care
- I**mplement plans to ensure wishes are honored
- V**oice decisions to family, friends and healthcare providers
- E**ngage in personal or community efforts to improve end-of-life care

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Using these Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive healthcare.
2. These materials include:
 - Instructions for preparing your advance directive, please read all the instructions.
 - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

ACTION STEPS

3. You may want to photocopy these forms before you start so you will have a clean copy if you need to start over.
4. When you begin to fill out the forms, refer to the gray instruction bars - they will guide you through the process.
5. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.
6. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, healthcare providers and/or faith leaders so that the form is available in the event of an emergency.

Introduction to Your Virginia Advance Medical Directive

This packet contains the *Advance Directive for Healthcare* which protects your right to refuse medical treatment you do not want or to request treatment you do want in the event you lose the ability to make decisions yourself.

The Virginia Advance Medical Directive lets you state your wishes about medical care in the event you cannot speak for yourself for any reason, including if you develop a terminal condition, meaning it is probable that you will not recover from the condition and either your death is imminent or you are in a persistent vegetative state and/or if you experience a mental health event that makes you incapable of making informed decisions about your care. This document also lets you name someone to make healthcare decisions on your behalf any time you are unable to make your own medical decisions, not only at the end of life.

Note: This document will be legally binding only if the person completing it is a competent adult (at least 18 years old).

Completing Your Virginia Advance Medical Directive

How do I make my Virginia Advance Medical Directive legal?

State law requires that you sign your Advance Medical Directive in the presence of two adult witnesses. Employees of healthcare facilities and physician's offices who act in good faith may serve as witnesses.

It is your responsibility to notify your attending physician that you have made an Advance Medical Directive. If you are comatose, incapacitated or otherwise mentally or physically incapable of communication, any other person may notify the physician of your advance directive.

Whom should I appoint as my agent?

Your agent is the person you appoint to make decisions about your medical care if you become unable to make those decisions yourself. Your agent may be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent must be an adult who clearly understands your wishes and is willing to accept the responsibility of making medical decisions for you. (An agent may also be called an "attorney-in-fact" or "proxy.")

You can appoint a second person as your alternate agent. The alternate will step in if the first person you name as agent is unable, unwilling or unavailable to act for you.

Should I add personal instructions to my Virginia Advance Medical Directive?

Yes. You can add additional instructions under the section "Other directions" on page 1. *This is important because it is unclear when you would be considered "terminal" under Virginia law.*

If you have appointed an agent, it is a good idea to write a statement such as, "Any questions about how to interpret or when to apply my Advance Medical Directive are to be decided by my agent." We also urge you to talk with your agent about your future medical care and describe what you consider to be an acceptable "quality of life."

Completing Your Virginia Advance Medical Directive (continued)

It is important to learn about the kinds of life-sustaining treatment you might receive. Consult your doctor for more information.

What if I change my mind?

You may revoke your Virginia Advance Medical Directive at any time by:

- signing and dating a written revocation,
- physically cancelling or destroying the document, or directing another to do so in your presence, or
- orally expressing your intent to revoke the document. Your revocation becomes effective when you notify your attending physician.

What other important facts should I know?

- If any of the terms of your Virginia Medical Directive conflict with the terms of an anatomical gift (organ donation), your physician and you must work to resolve the conflict. If you are unable or incapable of resolving the conflict, your agent must work with your physician to resolve the conflict.

INSTRUCTIONS

PRINT YOUR NAME

ADD PERSONAL
INSTRUCTIONS
(IF ANY)

VIRGINIA ADVANCE MEDICAL DIRECTIVE – PAGE 1 OF 7

I, _____,
willfully and voluntarily make known my wishes in the event that I am
incapable of making an informed decision, as follows:

I understand that my advance directive may include the selection of an agent as well as set forth my choices regarding health care. The term "health care" means the furnishing of services to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury or physical disability, including but not limited to, medications; surgery; blood transfusions; chemotherapy; radiation therapy; admission to a hospital, assisted living facility, or other health care facility; psychiatric or other mental health treatment; and life-prolonging procedures and palliative care.

The phrase "incapable of making an informed decision" means unable to understand the nature, extent and probable consequences of a proposed health care decision or unable to make a rational evaluation of the risks and benefits of a proposed health care decision as compared with the risks and benefits of alternatives to that decision, or unable to communicate such understanding in any way.

The determination that I am incapable of making an informed decision shall be made by my attending physician and a second physician or licensed clinical psychologist after a personal examination of me and shall be certified in writing. The second physician or licensed clinical psychologist shall not be otherwise currently involved in my treatment, unless such independent physician or licensed clinical psychologist is not reasonably available. Such certification shall be required before health care is provided, continued, withheld or withdrawn, before any named agent shall be granted authority to make health care decisions on my behalf, and before, or as soon as reasonably practicable after, health care is provided, continued, withheld or withdrawn and every 180 days thereafter while the need for health care continues.

If, at any time, I am determined to be incapable of making an informed decision, I shall be notified, to the extent I am capable of receiving such notice, that such determination has been made before health care is provided, continued, withheld, or withdrawn. Such notice shall also be provided, as soon as practical, to my named agent or person authorized by § 54.1-2986 to make health care decisions on my behalf. If I am later determined to be capable of making an informed decision by a physician, in writing, upon personal examination, any further health care decisions will require my informed consent.

APPOINTMENT OF AGENT

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

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

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OPTION I: APPOINTMENT OF AGENT (CROSS THROUGH IF YOU DO NOT WANT TO APPOINT AN AGENT TO MAKE HEALTH CARE DECISIONS FOR YOU)

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 _____
(primary agent)

is not reasonably available or is unable or unwilling to act as my agent, then I appoint _____,
(alternate agent)
of _____

(address and telephone number)

to serve in that capacity.

I hereby 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 exercising the power to make health care decisions on my behalf, my agent shall follow my desires and preferences as stated in this document or as otherwise known to my agent. My agent shall be guided by my medical diagnosis and prognosis and any information provided by my physicians as to the intrusiveness, pain, risks, and side effects associated with treatment or non-treatment. My agent shall not make any decision regarding my health care which he knows, or upon reasonable inquiry ought to know, is contrary to my religious beliefs or my basic values, whether expressed orally or in writing. If my agent cannot determine what health care choice I would have made on my own behalf, then my agent shall make a choice for me based upon what he believes to be in my best interests.

POWERS OF YOUR AGENT

OPTION II: POWERS OF MY AGENT (CROSS THROUGH ANY LANGUAGE YOU DO NOT WANT AND ADD ANY LANGUAGE YOU DO WANT)

The powers of my agent shall include the following:

- A. To consent to or refuse or withdraw consent to any type of medical care, treatment, surgical procedure, diagnostic procedure, medication and the use of mechanical or other procedures that affect any bodily function, including, but not limited to, artificial respiration, artificially administered nutrition and hydration, and cardiopulmonary resuscitation. This authorization specifically includes the power to consent to the administration of dosages of pain-relieving medication in excess of recommended dosages in an amount sufficient to relieve pain, even if such medication carries the risk of addiction or inadvertently hastens my death;
- B. To request, receive, and review any information, verbal or written, regarding my physical or mental health, including but not limited to, medical and hospital records, and to consent to the disclosure of this information;
- C. To employ and discharge my health care providers;
- D. To authorize my admission to or discharge (including transfer to another facility) from any hospital, hospice, nursing home, assisted living facility or other medical care facility. If I have authorized admission to a health care facility for treatment of mental illness, that authority is stated elsewhere in this advance directive.
- E. To authorize my admission to a health care facility for the treatment of mental illness for no more than 10 calendar days provided I do not protest the admission and a physician on the staff of or designated by the proposed admitting facility examines me and states in writing that I have a mental illness and I am incapable of making an informed decision about my admission, and that I need treatment in the facility; and to authorize my discharge (including transfer to another facility) from the facility;
- F. To authorize my admission to a health care facility for the treatment of mental illness for no more than 10 calendar days, even over my protest, if a physician on the staff of or designated by the proposed admitting facility examines me and states in writing that I have a mental illness and I am incapable of making an informed decision about my admission, and that I need treatment in the facility; and to authorize my discharge (including transfer to another facility) from the facility. [My physician or licensed clinical psychologist hereby attests that I am capable of making an informed decision and that I understand the consequences of this provision of my advance directive: _____.

(Physician signature)

(Print Physician name) _____ (Date)

A PHYSICIAN'S SIGNATURE **ONLY** REQUIRED IF YOU CHOOSE TO EXECUTE SECTION F AND/OR G TO ADDRESS SITUATIONS IN YOU ARE LIKELY TO PROTEST CARE THAT YOU BELIEVE YOU MAY NEED LATER. FOR MOST PEOPLE, SECTIONS F AND G WILL NOT APPLY AND MAY BE CROSSED OUT. YOUR PHYSICIAN'S SIGNATURE IS NOT OTHERWISE REQUIRED.

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SPECIFY CROSS
REFERENCE TO
OTHER SECTIONS
OF THIS DIRECTIVE
IF YOU WISH

G. To authorize the specific types of health care identified in this advance directive _____ even over my protest. My physician or licensed clinical psychologist hereby attests that I am capable of making an informed decision and that I understand the consequences of this provision of my advance directive:

(Physician signature)

(Print Physician name)

(Date)

H. To continue to serve as my agent even in the event that I protest the agent's authority after I have been determined to be incapable of making an informed decision;

I. 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 offers the prospect of direct therapeutic benefit to me;

J. To authorize my participation in any health care study approved by an institutional review board or research review committee pursuant 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;

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

L. To take any lawful actions that may be necessary to carry out these decisions, including the granting of releases of liability to medical providers.

Further, my agent shall not be liable for the costs of health care pursuant to his authorization, based solely on the authorization.

ADD PERSONAL
INSTRUCTIONS
(IF ANY)

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ADD PERSONAL
INSTRUCTIONS
(IF ANY)

OPTION III: HEALTH CARE INSTRUCTIONS

- A. I specifically direct that I receive the following health care if it is medically appropriate under the circumstances as determined by my attending physician:
- B. I specifically direct that the following health care not be provided to me under the following circumstances (you may specify that certain health care not be provided under any circumstances):

CROSS THROUGH
THIS OPTION IF
YOU DO NOT WANT
TO GIVE
INSTRUCTIONS
ABOUT YOUR
HEALTH CARE IF
YOU HAVE A
TERMINAL
CONDITION OR IF
YOU WANT TO GIVE
DIFFERENT
INSTRUCTIONS
USING EITHER OF
THE OTHER
"OPTION" CHOICES
HERE

OPTION IV: END OF LIFE INSTRUCTIONS

If at any time my attending physician should determine that I have a terminal condition where the application of life-prolonging procedures--including artificial respiration, cardiopulmonary resuscitation, artificially administered nutrition, and artificially administered hydration--would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

OPTION: OTHER DIRECTIONS ABOUT LIFE-PROLONGING PROCEDURES.

(If you wish to provide your own directions, or if you wish to add to the directions you have given above, you may do so here. If you wish to give specific instructions regarding certain life-prolonging procedures, such as artificial respiration, cardiopulmonary resuscitation, artificially administered nutrition, and artificially administered hydration, this is where you should write them.) I direct that:

HEALTH CARE
INSTRUCTIONS

ADD PERSONAL
INSTRUCTIONS
(IF ANY)

ANATOMICAL GIFT
OR ORGAN, TISSUE
OR EYE DONATION

PRINT THE NAME
ADDRESS AND
TELEPHONE
NUMBER OF YOUR
AGENT FOR
ANATOMICAL
GIFTS. CROSS
THROUGH IF YOU
DO NOT WANT TO
APPOINT AN AGENT
TO MAKE AN
ANATOMICAL GIFT
OR ANY ORGAN,
TISSURE OR EYE
DONATION FOR
YOU

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VIRGINIA ADVANCE MEDICAL DIRECTIVE — PAGE 6 OF 7

OPTION: My other instructions regarding my care if I have a terminal condition are as follows:

In the absence of my ability to give directions regarding the use of such life-prolonging procedures, it is my intention that this advance directive shall be honored by my family and physician as the final expression of my legal right to refuse health care and acceptance of the consequences of such refusal.

OPTION V: APPOINTMENT OF AN AGENT TO MAKE AN ANATOMICAL GIFT OR ORGAN, TISSUE OR EYE DONATION

Upon my death, I direct that an anatomical gift of all or any part of my body or certain organ, tissue or eye donation may be made pursuant to Article 2 (§ 32.1-289.2 et seq.) of Chapter 8 of Title 32.1 and in accordance with my directions, if any. I hereby appoint

_____ as my
(name of agent)

agent, of

(address and telephone number of agent)

to make any such anatomical gift or organ, tissue or eye donation following my death. I further direct that: (declarant's directions concerning anatomical gift or organ, tissue or eye donation):

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

VIRGINIA ADVANCE MEDICAL DIRECTIVE — PAGE 7 OF 7

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 (i) with a signed, dated writing; (ii) by physical cancellation or destruction of this advance directive by myself or by directing someone else to destroy it in my presence; or (iii) by my oral expression of intent to revoke.

SIGN AND DATE
THE DOCUMENT

(date)

(signature of declarant)

WITNESSING
PROCEDURE

The declarant signed the foregoing advance directive in my presence.

Witness _____

WITNESSES SIGN
HERE

Witness _____

You Have Filled Out Your Advance Directive, Now What?

1. Your Virginia *Advance Medical Directive* is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.
2. Give photocopies of the signed original to your agent and alternate agent, doctor(s), family, close friends, clergy and anyone else who might become involved in your healthcare. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.
3. Be sure to talk to your agent and alternate agent, doctor(s), clergy, family and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.
4. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.
5. Remember, you can always revoke your Virginia Directive. If you revoke your Directive, make sure you notify your agent and alternate agent, your family and your doctors.
6. Be aware that your document will not be effective in the event of a medical emergency. Ambulance personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate order that states otherwise. These orders, commonly called "non-hospital do-not-resuscitate orders," are designed for people whose poor health gives them little chance of benefiting from CPR. These orders must be signed by your physician and instruct ambulance personnel not to attempt CPR if your heart or breathing should stop.

Currently not all states have laws authorizing non-hospital do-not-resuscitate orders. We suggest you speak to your physician for more information. **Caring Connections does not distribute these forms.**