

# VIRGINIA ADVANCE MEDICAL DIRECTIVE

I, \_\_\_\_\_, intentionally 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 in addition to setting 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, nursing home, 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; 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 currently involved in my treatment, unless a second physician or licensed clinical psychologist uninvolved in my treatment 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 Such certification shall be required before health care is provided, continued, withheld or withdrawn; before any named agent shall be granted authority to make health care decisions on my behalf; and before, or as soon as reasonably practicable after, health care is provided, continued, withheld or withdrawn and every 180 days thereafter while the need for health care continues.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receiving such notice, that such a determination has been made before health care is provided, continued, withheld or withdrawn. Such notice also shall be provided, as soon as practical, to my named agent or person authorized by §54.1-2986 of the Code of Virginia 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, then any further health care decisions will require my informed consent.

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

(YOU MAY INCLUDE IN THIS ADVANCE DIRECTIVE ANY OR ALL OF SECTIONS I THROUGH V BELOW.)

## Section I: Appointment Of Agent

(CROSS THROUGH SECTION I AND SECTION II BELOW IF YOU DO NOT WANT TO APPOINT AN AGENT TO MAKE HEALTH CARE DECISIONS FOR YOU.)

I hereby appoint the following as my primary agent to make health care decisions on my behalf as authorized in this document:

NAME OF PRIMARY AGENT	TELEPHONE	FAX IF ANY
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ADDRESS	E-MAIL IF ANY
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If the above-named primary agent is not reasonably available or is unable or unwilling to act as my agent, then I appoint the following as successor agent:

NAME OF SUCCESSOR AGENT	TELEPHONE	FAX IF ANY
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ADDRESS	E-MAIL IF ANY
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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 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 nontreatment. My agent shall not make any decision regarding my health care which he or she 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 or she believes to be in my best interests.

My agent shall not be liable for the costs of health care that he or she authorizes, based solely on that authorization.

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## Section II: Powers Of My Agent

(CROSS THROUGH ANY POWERS IN THIS SECTION II THAT YOU DO NOT WANT TO GIVE YOUR AGENT AND ADD ANY POWERS OR INSTRUCTIONS THAT YOU DO WANT TO GIVE YOUR AGENT.)

The powers of my agent shall include the following:

A. To consent to or refuse or withdraw consent to any type of health 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 of inadvertently hastening my death.

My agent's authority under this Subsection A shall be limited by any specific instructions I give in Section IV below regarding my health care if I have a terminal condition.

B. 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.

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 in Subsections E and/or F below.

E. To authorize my admission to a health care facility for the treatment of mental illness for no more than 10 calendar days provided that I do not protest the admission and provided that 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, that 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 if I 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, that 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.

*(If you give your agent the powers described in this Subsection F, your physician must complete the following attestation.)*

<b>Physician attestation: I am the physician or licensed clinical psychologist of the declarant of this advance directive. I hereby attest that I believe the declarant to be presently capable of making an informed decision and that the declarant understands the consequences of this provision of this advance directive.</b>	
PHYSICIAN SIGNATURE	DATE
PHYSICIAN NAME PRINTED	

G. To authorize the following specific types of health care identified in this advance directive even if I protest. *(Specifically cross-reference any applicable sections of this advance directive.)*

*(If you give your agent the powers described in this Subsection G, your physician must complete the following attestation.)*

<b>Physician attestation: I am the physician or licensed clinical psychologist of the declarant of this advance directive. I hereby attest that I believe the declarant to be presently capable of making an informed decision and that the declarant understands the consequences of this provision of this advance directive.</b>	
PHYSICIAN SIGNATURE	DATE
PHYSICIAN NAME PRINTED	

H. To continue to serve as my agent even if 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 if the study offers the prospect of direct therapeutic benefit to me.

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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 the study 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:

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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.

*(Add below any additional powers you give your agent, limits you impose on your agent or other information to guide your agent.)*

I further instruct my agent as follows:

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## Section III: Health Care Instructions

*(CROSS THROUGH SUBSECTIONS A AND/OR B BELOW IF YOU DO NOT WANT TO GIVE ADDITIONAL SPECIFIC INSTRUCTIONS ABOUT YOUR HEALTH CARE.)*

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:

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B. I specifically direct that the following health care not be provided to me under the following circumstances:

*(You also may specify that certain health care not be provided under any circumstances.)*

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## Section IV: Instructions About End-of-life Care (“Living Will”)

*(CROSS THROUGH THIS SECTION IV IF YOU DO NOT WANT TO GIVE SPECIFIC INSTRUCTIONS ABOUT YOUR HEALTH CARE IF YOU HAVE A TERMINAL CONDITION.)*

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.

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 my acceptance of the consequences of such refusal.

*(CROSS THROUGH SUBSECTIONS A AND/OR B BELOW IF YOU DO NOT WANT TO GIVE ADDITIONAL INSTRUCTIONS ABOUT CARE AT THE END OF YOUR LIFE.)*

### A. OTHER DIRECTIONS ABOUT LIFE-PROLONGING PROCEDURES

*(If you wish to provide your own directions about life-prolonging procedures, or if you wish to add to the directions you have given above, you may do so in this Subsection A. 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. If you give specific instructions in this Subsection A, cross through any of the language above in this Section IV if your specific instructions that follow are different.)*

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I direct that:

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## B. DIRECTIONS ABOUT CARE OTHER THAN LIFE-PROLONGING PROCEDURES

*(You may give here any other instructions about your care if you have a terminal condition aside from your instructions about life-prolonging procedures, which are addressed above.)*

I direct that:

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## Section V: Appointment Of An Agent To Make An Anatomical Gift Or Organ, Tissue Or Eye Donation

*(CROSS THROUGH THIS SECTION V IF YOU DO NOT WANT TO APPOINT AN AGENT TO MAKE AN ANATOMICAL GIFT OR ANY ORGAN, TISSUE OR EYE DONATION FOR YOU.)*

Upon my death, I direct that an anatomical gift of all of my body or certain organ, tissue or eye donations may be made pursuant to Article 2 (§ 32.1-289.2 et seq.) of Chapter 8 of Title 32.1 of the Code of Virginia and in accordance with my directions below, if any. I hereby appoint as my agent to make any such anatomical gift or organ, tissue or eye donation following my death (choose one):

The same agent (and alternate) named in Section I above; **OR**

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NAME OF AGENT	TELEPHONE	FAX IF ANY
ADDRESS	E-MAIL IF ANY	

I further direct that:

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*(Declarant's directions, if any, concerning anatomical gift or organ, tissue or eye donation.)*

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*(You must sign below in the presence of two witnesses.)*

**AFFIRMATION AND RIGHT TO REVOKE:** By signing below, I state 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 that 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.

\_\_\_\_\_  
SIGNATURE OF DECLARANT

\_\_\_\_\_  
DATE

The declarant signed the foregoing advance directive in my presence.

\_\_\_\_\_  
(WITNESS)

\_\_\_\_\_  
(WITNESS)

*This form is provided by the Virginia Hospital & Healthcare Association as a service to its members and the public. (July 2009, www.vhha.com)*