VIRGINIA ADVANCE DIRECTIVE FOR HEALTH CARE

to Appoint a Health Care Agent

This advance directive ("AD") complies with the Virginia Healthcare Decisions Act. You are not required to use this form to create an AD. If you choose to use a different form, you should consult with an attorney or your health care provider to be sure the different form will be valid under Virginia law.

As long as it is signed and witnessed (on page 3), you may complete any or all of the parts of this AD that you want. Cross out or leave blank any parts that you do not want to use.

Your AD is turned on only when you are found to be unable to make informed decisions about your care. That finding must be made by (a) your attending physician and (b) a second physician or clinical psychologist (or, if you're in a coma or otherwise unconscious, you're your physician) after they personally examine you. Your AD is turned off when a physician examines you and finds that you are able to make informed decisions again. (There is an option to have your AD turned on by just one professional for the sole purpose of agent consent to admission to a mental health care facility. See Power 5 on page 2 for more details.)

I, ____(date of birth: ________________), make this advance directive in case I am not able to make health care decisions for myself. This advance directive says what I do want and what I do not want for my health care.

Section 1: Health Care Decision Maker (My "Agent")

A. Who I Pick to be My Agent

I appoint ____ to make health care decisions for me when I cannot make those decisions myself.

First agent's contact information:

Ph. No. (home): ________________________ (cell): ___________________________

Ph. No. (work): ______________________ Email:______________________________

Home Address:____

I also pick a person to be my agent if the first person I picked is not available, able or willing to act as my agent. My back-up agent is ______________________________.

Back-up agent's contact information:

Ph. No. (home): ________________________ (cell): ___________________________

Ph. No. (work): ______________________ Email:______________________________

Home Address:____

My agent will have full power to make health care decisions for me based on this advance directive. My agent will have this power only during a time when I am not able to make informed decisions about my health care.

I want my agent to follow what I have written in this advance directive. My agent may also be guided by information that I have given my agent in other ways, such as in conversation. If my agent cannot tell what choice I would have made, then my agent should choose what he or she believes to be in my best interests.

I want my agent and health care providers to communicate with me and consider my views even when I am unable to make my own decisions and the agent has the power to make decisions for me.

These are the powers that your agent will have.

You may cross through any powers that you do not want to give your agent.

If you have questions about what the powers mean, the "What it means to give powers to your health care agent" sheet may be helpful. It can be found on the VirginiaAdvanceDirective.org website.

B. What My Agent Can Do On My Behalf

My agent will have power…

1. To consent to or refuse consent to or withdraw consent to any type of health care, treatment, surgical procedure, diagnostic procedure, and medication.

   This may include use of a breathing machine, tube feeding, IV fluids, or CPR. It also includes higher than recommended doses of pain-relieving medication in order to relieve pain. This applies even if the medication carries the risk of addiction or of unintentionally hurrying my death.

2. To ask for, receive and review oral or written information about the health care decisions that need to be made. This includes medical and hospital records. My agent can also allow this information to be shared with others as needed to carry out my advance directive wishes.

3. To hire and fire my health care providers.

Power 5 Option:
Virginia law lets you authorize your agent to make the decision about admission to a mental health care facility on the basis of just *one* professional examining you and determining you cannot make an informed decision. Any other treatment decisions beyond admission to a mental health care facility will still require the usual determination process by (a) your attending physician + (b) a second physician or clinical psychologist. If you want to include this part of Power 5, you need to check the box.

Power 9: If you have any specific instructions about visitation, you can attach additional pages to this AD. Note: other laws and regulations may limit an agent's power to make visitation decisions.

You may add any additional details about the powers (e.g., "My agent may not fire Dr. Smith"). Note: any attached page with instructions must be signed and witnessed, too.

Part C lets you give your agent the power to consent to treatment that you say "no" to. This power applies only if you cannot make informed decisions. If you do not want to give your agent this power, you can skip or cross through Part C.

This power has two parts:
1. You can give your agent the power to consent over your objection to inpatient mental health admission
and/or
2. You can give your agent the power to consent over your objection to other health care

You can also exclude specific treatments that you always want to be able to object to.

IMPORTANT: You need to have one of the licensed professionals listed in the box sign this page to make Part C legally binding. Before signing, the professional will check to see if you understand the consequences of giving your agent the powers described on this page.
If you are not completing Part C, you do not need to have this page signed.

4. To consent to my admission to or transfer to a hospital, hospice, nursing home, assisted living facility or other health care facility, and to authorize my discharge from any such facility.
5. To consent to my admission to or transfer to a mental health care facility when it is recommended by my health care providers, and to authorize my discharge from any such facility.
   The admission can be for up to the maximum time permitted by current law. At the time I made this advance directive the maximum was ten (10) calendar days.
   ☐ Power 5 option: My agent may exercise this power after one of the following professionals determines that I am not able to make an informed decision about admission: an attending physician, a psychiatrist or clinical psychologist, a psychiatric nurse practitioner, a clinical social worker, or a designee of the local community services board who is trained to assess capacity.
6. To continue to act as my agent as long as I am unable to decide for myself, even if I state that I want to fire my agent.
7. To consent to my participation in any health care study if the study offers the chance of therapeutic benefit to me.
   The study must be approved by an institutional review board or research review committee according to applicable federal or state law.
8. To consent to my participation in any health care study that aims to increase scientific understanding of a condition that I may have or to promote human well-being, even though it offers no direct benefit to me.
   The study must be approved by an institutional review board or research review committee according to applicable federal or state law.
9. To make decisions about visitation when I am admitted to any health care facility.
   ☐ I have attached visitation instructions that my agent must follow to this advance directive.
10. To take any lawful actions needed to carry out these decisions. This may include signing releases of liability to medical providers or other health care forms.

C. What My Agent Can Do Over My Objection

When I am not able to make informed decisions about my health care, I may say "no" to treatment that I actually need. If my agent and my physician believe that treatment is medically appropriate, my agent has the power:

☐ ____ 1. To consent to my admission to a mental health care facility as permitted by law, even if I object.

and/or

☐ ____ 2. To consent to other health care that is permitted by law, even if I object. This authority includes all health care except for what I have written in the next sentence or elsewhere in this document. My agent does **not** have the authority to consent to ________________________________ over my objection.

I am a licensed: ☐ physician, ☐ clinical psychologist, ☐ physician assistant, ☐ nurse practitioner, ☐ professional counselor, ☐ clinical social worker. I am familiar with the person who has made this advance directive for health care. I attest that this person is presently capable of making an informed decision and that this person understands the consequences of the special powers given to his/her agent by this Subsection C of this advance directive.

____
Signature Date

____
Printed Name and Address

If you leave this section blank, your agent will have the authority to donate your organs, eyes and tissues or your whole body. If you do not want your agent to have that authority, write in the box "I do not want to be an organ donor."

If you want to be an organ donor, check only 1 box and initial the line.

If you want to be an organ donor, you may also use this space to write any specific instructions you wish to give about organ donation.

You can also register or change your directions on the donor registry, www.DonateLifeVirginia.org.

Two adult witnesses are needed to make your advance directive valid. Any person over the age of 18 may be a witness. This includes a spouse or relative, as well as employees of health care facilities and physician's offices who act in good faith.

This form meets 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.

Note: If you have added pages with instructions, those pages should be signed and witnessed, too.

This advance directive should be accepted in other states based on "reciprocity" laws that honor valid out of state documents. Check with your health care provider.

Section 2: Organ Donation

☐ _____ 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.

OR

☐ _____ I donate my whole body for research and education.

Section 3: Required Signatures

Right to Revoke: I understand that I may cancel all or part of my AD at any time that I am able to understand the consequences of doing so.

Affirmation: I am signing below to show that I understand this document and that I made it voluntarily.

_______________ _______________________________________

Date Signature

The above person signed this advance directive in my presence.

_______________________________ _______________________________

Witness Signature Witness Printed

_______________________________ _______________________________

Witness Signature Witness Printed

It is your responsibility to provide a copy of your advance directive to your health care providers. You also should provide copies to your agent, close relatives and/or friends.

In addition to sharing hard copies, you are encouraged to store your advance directive in Virginia's free Advance Directive Registry located at the Virginia Department of Health website: https://www.connectvirginia.org/adr/.

If you have stored your advance directive in the Registry, initial here: ________