# Advance Directive

This document has been prepared and distributed as an informational service.

## INSTRUCTIONS AND DEFINITIONS

### Introduction

This form is a combined Durable Power of Attorney for Health Care and Living Will for use in Virginia.

*With this form, you can:*

- Appoint someone to make healthcare decisions for you if, in the future, you are unable to make those decisions for yourself.

*And/or*

- Indicate what health care treatment you do or do not want if in the future you are unable to make your wishes known or are incapacitated.

  This document also gives you the ability to make mental health decisions regarding future admissions with your attending physician's knowledge and signature.

### Directions

- Read each section carefully.
- Talk to the person you plan to appoint to make sure that he/she understands your wishes, and is willing to take the responsibility.
- Place the initials of your name in the blank before those choices you want to make.
- Fill in only those choices that you want. Your advance directive will be valid for whatever part(s) you fill in, as long as it is properly signed and witnessed .
- Cross through any sections that you do not wish to make a decision on at this time.
- Add any special instructions in the blank spaces provided. You can write additional comments on a separate sheet of paper, but you should indicate on the form that there are additional pages to your advance directive.
- Sign the form and have it witnessed.
- Give your doctor, your nurse, your durable power of attorney, your family, and anyone else who might be involved in your care, a copy of your advance directive and discuss it with each person.
- Understand that you may change or cancel this document at any time.

## Words You Need To Know

**Advance Directive**
A written document that tells what a person wants or does not want if, in the future, he/she can't make his/her wishes known about healthcare treatment.

**Artificial Nutrition and Hydration**
When food and water are given to a person through a tube.

**General Comfort Measures**
Care that helps to keep a person comfortable but does not intend to cure. Comfort care, pain and symptom management.

**CPR (Cardiopulmonary Resuscitation)**
Treatment to try and restart a person's breathing or heartbeat. CPR may be done by pushing on the chest, by putting a tube down the throat, or by other treatments.

**Durable Power of Attorney for Health Care/Health Care Surrogate**
An advance directive that appoints someone to make medical decisions for a person if in the future he/she can't make his/her own medical decisions.

**Life-Sustaining Treatment**
Any medical treatment that is used to keep a person from dying. A breathing machine, CPR, and artificial nutrition and hydration are examples of life-sustaining treatments.

**Living Will**
An advance directive that tells what medical treatment a person does or does not want if he/she is not able to make his/her wishes known.

**Organ and Tissue Donation**
When a person permits his/her organs (such as eyes or kidneys) and other parts of the body (such as skin) to be removed after death to be transplanted for use by another person or to be used for experimental purposes.

**Persistent Vegetative State**
When a person is unconscious with no reasonable expectation of regaining consciousness even with medical treatment. The body may move and eyes may be open but as far as anyone can tell, the person can't think or respond.

**Terminal Condition**
An on-going condition caused by injury or illness that has no cure and from which doctors expect the person to die even with medical treatment.

For More Information Call:
Patient Relations 703.558.6195 or Pastoral Care 703.558.6128

MR0020

VIRGINIA HOSPITAL CENTER

**ADVANCE DIRECTIVE**



122682-9250-052410

PATIENT LABEL

## MENTAL HEALTH DECISIONS

*(If you give your agent the powers described in this Subsection below, your physician must complete the following attestation.)* Cross through options if they do not apply to you.

I authorize my admission to a health care facility for the treatment of mental illness for no more then 10 calendar days, ***even over my protest***, if a physician on staff examines me and states 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.

Your Printed Name _____

Your Signature _____ Date _____

As the physician or licensed clinical psychologist I hereby attest that at the time that the patient signed the advance directive he/she was capable of making an informed decision and understood the consequences of this provision of his/her advance directive:

Doctor's Printed Name _____

Doctor's Signature _____ Date _____

*Cross out any section that does not apply to you*

I authorize the specific types of health care identified in this advance directive ***even over my protests.***

Your Printed Name _____

Your Signature _____ Date _____

As the physician or licensed clinical psychologist I hereby attest that at the time that the patient signed the advance directive he/she was capable of making an informed decision and understood the consequences of this provision of his/her advance directive:

Doctor's Printed Name _____

Doctor's Signature _____ Date _____

| **Comfort Care** |
|---|
| ☐ I want to be kept as comfortable and free of pain as possible, even if it leads to reduced consciousness. |
| ☐ Other wishes: |
| |
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| |

| **Other Directions** | |
|---|---|
| You have the right to be involved in all decisions about your medical care. If you have wishes not covered in other parts of this document, please indicate them here. | |
| **Organ Donation** | **Autopsy** |
| ☐ I want to donate all of my organs and tissues. | ☐ I agree to an autopsy if my doctors wish it. |
| ☐ I only want to donate these organs and tissues: | ☐ I do not want an autopsy. |
| | ☐ Other wishes: |
| | |
| | |
| ☐ I do not wish to donate any of my organs or tissues. | |
| | |
| ☐ Other wishes: | |
| | If you wish to say more about any of the above choices, or if you have any other statements to make about your medical care, you may do so on a separate sheet of paper. If you do so, put the number of pages you are adding here: |
| | |
| | |

**SIGNATURES**

**You and two witnesses must sign this document in order for it to be legal.**
**Must be age 18 or older to witness.**

| **Your Signature** | |
|---|---|
| *By my signature below, I show that I understand the purpose and the effect of this document.* | Date |
| Print Name | Signature |

| **Your Witnesses' Signatures** | |
|---|---|
| I believe the person who has signed this advance directive to be of sound mind, that he/she signed or acknowledged this advance directive in my presence, and that he/she appears not to be acting under pressure, duress, fraud, or undue influence. | |
| Witness #1 | Witness #2 |
| Print Name | Print Name |
| Signature Date | Signature Date |
| Address | Address |

## APPOINTMENT OF MY AGENT (DURABLE POWER OF ATTORNEY FOR HEALTH CARE)

| ☐ I appoint this person to make decisions about my medical care if there ever comes a time when I cannot make those decisions myself: | ☐ If the person I appointed first cannot or will not make decisions for me, I appoint this person: |
|---|---|
| **Primary Agent** | **Successor Agent** |
| Name: | Name: |
| Home Phone: | Home Phone: |
| Work Phone: | Work Phone: |
| Address: | Address: |

☐ I have not appointed anyone to make health care decisions for me in any other document.

**I want the person I have appointed, my doctors, my family, and others to be guided by the decisions I have made below regarding all health care decisions. I understand my agent has powers only if I am incapacitated or unable to make my wishes known.**

I understand that my advance directive may include the selection of an agent in addition to setting forth my choices regarding health care. **Health Care** is defined as furnishing services to any individual for the purpose of preventing, alleviating, curing, healing 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 and life prolonging procedures and palliative care.

**Incapable of making an informed decision** means that I am unable to understand the nature, extent and probable consequences of a proposed healthcare decision or unable to make a rational evaluation of the risks, and benefits of a proposed healthcare decision. The Virginia Code for Advance Directives requires that two physicians are necessary to determine incapacity. One is your attending physician and another is a doctor not involved in your care. Both physicians must fully examine you and document their findings in your medical record.

## MY END OF LIFE CARE

**Life Sustaining Treatments if I am in a terminal condition or Persistent Vegetative State (PVS).**

☐ I do not want life-sustaining treatments (including CPR) started. If life-sustaining treatments are started, I want them stopped.

☐ I want life-sustaining treatments that my doctors think are best for me.

☐ Other wishes:

**Artificial Nutrition and Hydration**

☐ I do not want artificial nutrition started if it would be the main treatment keeping me alive. If artificial nutrition is started, I want it stopped.

☐ I do not want artificial hydration started if it would be the main treatment keeping me alive. If artificial hydration is started, I want it stopped.

☐ I want artificial nutrition even if it is the main treatment keeping me alive.

☐ I want artificial hydration even if it is the main treatment keeping me alive.

☐ Other wishes: