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 10), 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.

If you do not want to pick an agent to make health care decisions for you when you cannot make the decisions yourself, then cross out or skip **Section 1**.

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 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.)

VIRGINIA ADVANCE DIRECTIVE FOR HEALTH CARE

with Sections for Medical, Mental, and End-of-Life Health Care

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.

If you appointed an agent on page 1, these are the powers that he/she 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, you might find the "What it means to give powers to your health care agent" sheet helpful. It can be found on the www.VirginiaAdvanceDirectives.org website.

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 need to say so on page 8. 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").

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 providers as needed to carry out my advance directive wishes.
3. To hire and fire my health care providers.
4. To consent to my admission to, transfer to, or discharge from a hospital, hospice, nursing home, assisted living facility or other health care facility.
5. To consent to my admission to a mental health care facility when it is recommended by my health care providers.
   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 and certified 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. My agent must follow any directions on visitation I give on page 8 of 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.

Additional details:

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 act over your objection to inpatient mental health admission

and/or

2. You can give your agent the power to act 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 following licensed professionals sign this page to make Part C legally binding: a physician, clinical psychologist, physician assistant, nurse practitioner, professional counselor, or clinical social worker. This professional checks that 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.

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 I need that treatment, 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

763a

You may use **Section 2** to give directions about your health care. You may skip over or cross out any parts that you do not want to fill out. You can use these parts even if you do not pick an agent.

Part A lets you provide background information to your health care providers. It includes no instructions.

If you have symptoms that show you need mental health care, you can write them here and on page 6.

You can also provide medication information by attaching a list of your medications to this AD, or writing where people can get your medication information (e.g., calling your primary care doctor).

The information in your AD may be shared by your health care provider with other health care providers so that treatment can be given in line with your AD. You can help your different providers get in contact with each other by providing their phone numbers here.

Section 2: My Health Care Preferences and Instructions

My preferences and instructions for my health care are written in this section. My health care agent and any health care providers working with me are directed to provide care in line with my stated instructions and preferences. *I understand that my providers do not have to follow preferences or instructions that are medically or ethically inappropriate or against the law.*

A. My Health Conditions and Current Treatments

1. My current health condition(s) and important things about my condition(s) that health care providers should know:

2. Symptom(s) that indicate I need prompt medical attention:

3. My medications and dosages as of ____/____/20____:

Medication	Dose	How/when I take it

☐ See back of this page for more ☐ See attached list for more

4. Other important information regarding medications (allergies, side effects):

B. Information Sharing

My current providers, who have information to help with my care, are:

Name	Provider type (e.g., PCP, psychiatrist)	Phone number

C. Emergency Contacts

I authorize the health care providers and other people helping me to contact my health care agent. This authorization includes if I am admitted to a mental health facility.
I also authorize them to contact the following people to share information about my location, condition and needs:

Name: _____ Relationship to me: _____

Ph. No. (home): _____ (cell): _____

Ph. No. (work): _____ Email: _____

Home Address: _____

Limit of details to share, if any: _____

Name: _____ Relationship to me: _____

Ph. No. (home): _____ (cell): _____

Ph. No. (work): _____ Email: _____

Home Address: _____

Limit of details to share, if any: _____

D. Medication

Part D lets you give your preferences for medications. You may refer to specific medications or types of medications.

Your physician must consider your preferences. But medication decisions must be based on his or her clinical judgment too.

Your physician is not required to follow preferences that are medically or ethically inappropriate.

You have the option of telling providers more information about your choices—it can help them to better follow your wishes.

1. Medication Preferences

I prefer that the following medications (or classes or types of medication) be tried first in a crisis or emergency:

Medication name or class	As treatment for…

I prefer these medications because:

In general, your agent cannot authorize and your physician cannot order use of the medications that you refuse here. There are some narrow exceptions permitted by law, such as emergencies.

You may leave the option open for your agent to consent to a refused medication if circumstances indicate the medication really is the most appropriate one under the circumstances.

2. Medication Authorization and Refusal Instructions

General authorization to consent to medications: Generally, I authorize my agent to consent to medications that my treating physician says are appropriate.

Medication refusal instructions: Although I generally authorize my agent to consent to medications, I specifically do **not** consent to the medications listed below. (This includes brand-name, trade-name, or generic equivalents.)

Although I do not consent to these medications, I realize that my condition and needs may change. So, I also state whether my agent can consent to the medication if necessary. My agent should consent only if my physician finds that the medication is clearly the most appropriate treatment for me under the circumstances.

Medication name or class that I do not want	As treatment for…	My agent can authorize it if necessary	
		Yes	No
		Yes	No
		Yes	No

You have the option of telling providers more information about your choices—it can help them to better follow your instructions.

I do not want these medications because:

You can add any other preferences about medication here, such as whether you prefer shots, pills, or liquid forms of medicines.

3. Additional preferences about medications:

E. Mental Health Crisis Intervention

If you have, previously had, or are at risk of a mental health condition, **Part E** allows you to provide information about your condition and your preferences to help your agent and health care providers meet your needs in a mental health crisis.

1. My Past Experience

a. Symptoms I might experience during a period of crisis:

Your health care providers must consider your preferences relating to the location and type of care but their ability to follow them may be limited by clinical, legal and administrative requirements.

b. Interventions that may help me:

Your health care providers must consider your preferences relating to the location of care but their ability to follow them may be limited by clinical, legal and administrative requirements.

You can use **E.3** to show which emergency intervention you prefer if one has to be used. Rank the four types—you can rank all of them or some of them or leave this part blank.

Your health care providers must consider your preferences but their ability to follow them may be limited by clinical, legal and administrative requirements.

If you want to, you can put details about why you put them in the order that you did—for example, "shots work quickest," "I usually take pills even in behavioral health emergency situations," or "I have had a traumatic experience that makes seclusion a very bad option for me."

c. Interventions or other factors that may make things worse:

2. Crisis units, inpatient facilities, and hospitals:

a. I prefer to be treated at the following facilities if 24-hour care is required:

because:

b. I prefer not to be treated at the following facilities

because:

c. Facility staff can help me by doing the following:

d. I prefer to be transported by:

Contact information for transporter:

3. Behavioral emergency interventions: If I am in immediate danger of harming myself or other people, emergency interventions may be medically necessary. I am listing the four types of emergency interventions in order of my preference here.

____ Medication in pill or liquid form

____ Physical restraint

____ Medication by injection

____ Seclusion

I have put them in this order because:

You may use this space to provide any other information that is important to your care that may not be addressed above. If you need more space, you may attach additional documents. If you use attachments, you should be sure to describe them clearly here.

If you gave your agent the power to make visitation decisions, your agent must make visitation decisions based on any instructions you write here.

More information about ECT is available from groups like NAMI (https://www.nami.org/Learn-More/Treatment) and the Mayo Clinic (http://www.mayoclinic.org/tests-procedures).

You can use **Part G** to request that some tasks be taken care of while you are hospitalized.

Although expressing your wishes could be very useful, these statements do not necessarily have any legal effect. For example, your health care agent is not legally required to pay your bills.

F. Other Health Care Details

1. In General

2. Visitation Instructions

If I am in a health care facility, this is how I want visitation to be handled:

3. Electroconvulsive Therapy (ECT) Instructions

☐ ____ A. I authorize my agent to consent to electroconvulsive therapy if my doctor(s) say that it is medically appropriate.

OR

☐ ____ B. I do not consent to electroconvulsive therapy.

G. Life Management Requests

☐ I have a crisis plan that can be found:_____

1. If I am hospitalized, I would like for the following tasks to be carried out at my home:

2. If I am hospitalized, I would like the following tasks to be carried out in regard to my job and other outside activities and responsibilities:

3. If I am unable to care for my child(ren), then my first choice to care for them is:

Name:_____ Relationship: _____

Address: _____ Email: _____

Phone (home): _____ (cell): _____ (work): _____

763a

Part H lets you give details about what treatment you would want if you cannot recover from a severe illness or injury.

The first type of condition that you can give treatment instructions for is in case your death is expected very soon. For example, if you were in the last stage of cancer.

For H.1, check only 1 box and initial the line.

If the pre-made options above do not fit what you want, you may write your own preferences and instructions.

The second type of condition that you can give treatment instructions for is in case your brain becomes severely and permanently damaged. For example, if you were in a permanent coma.

Sometimes people in a permanent coma can be kept alive for a long time, even though they are not expected to recover. If this were to happen, you may limit how long treatments may be tried before they are stopped if your condition does not improve.

For H.2, check only 1 box and initial the line.

If the pre-made options do not fit what you want, you may write your own preferences and instructions.

H. Life-Prolonging Treatment

1. If my doctor determines that my death is imminent (very close) and medical treatment will not help me recover, then:

□ ____ 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.

□ ____ 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.

□ ____ Other choices, as follows:

2. 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, then:

□ ____ 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.

□ ____ 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.

□ ____ I want to try treatments for a period of time in the hope of some improvement of my condition. I suggest _____ as the period of time after which such treatment should be stopped if my condition has not improved. Any agent or surrogate may specify the exact time period in consultation with my physician. I understand that I still will receive treatment to relieve pain and make me comfortable.

□ ____ Other choices, as follows:

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.

Section 3: 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 4: 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 _____

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.

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: _____