

PATIENT NAME

MR#

## VIRGINIA ADVANCE MEDICAL DIRECTIVE

I want to make my wishes known in advance in case I become unable to make an informed decision about my medical care. I, \_\_\_\_\_ willfully and voluntarily make known my desire and do hereby declare:

*(Cross through this box and initial if you do not want to appoint an agent to make health-care decisions)*  
**“Durable Medical Power of Attorney for Health Care” Portion of Advance Medical Directive**

I hereby appoint the following as my primary agent to make health care decisions for me if I become incapable of making decisions for myself:

Primary agent name \_\_\_\_\_ Day phone \_\_\_\_\_

Address \_\_\_\_\_ Evening phone \_\_\_\_\_

If my primary agent is unavailable or is unable or unwilling to make decisions for me, I appoint the following person as my substitute agent:

Substitute agent name \_\_\_\_\_ Day phone \_\_\_\_\_

Address \_\_\_\_\_ Evening phone \_\_\_\_\_

Under Virginia law, the powers of my agent include: *(You may cross through and initial any statement)*

- 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 (being put on a respirator), artificially administered nutrition and hydration using an IV or feeding tube, and cardiopulmonary resuscitation (CPR). This includes the power to consent to amounts of pain-relieving medication in excess of recommended dosages in order to relieve pain, even if such doses may make me addicted or unintentionally hasten my death.
- B. To request, receive, and review any information, verbal or written, regarding my physical or mental health and to consent to the use or disclosure of this information;
- C. To employ and discharge any health-care providers;
- D. To make decisions regarding visitation;
- E. To consent to any participation in human research (clinical research) consisting of (1) therapeutic research and (2) nontherapeutic research that creates no more than a minor increase over minimal risk to me.
- F. To agree to my admission to or discharge from any hospital, hospice, nursing home, adult home or other medical care facility, other than for treatment of mental illness requiring admission procedures provided in Va. Code Section 37.1-63 et seq; and
- G. To take any lawful actions to carry out these decisions including granting releases of liability to those who provide my medical care.

# GUIDELINES FOR MY AGENT ABOUT MY TREATMENT CHOICES

*You are not required to provide any written instructions or make any selections. If you choose not to provide any instructions, your health care agent will make decisions based on his/her understanding of your oral instructions or what is considered in your best interest.*

**My instructions about life-prolonging treatment:** *(Initial only ONE box in this section.)*

If it is reasonably certain that I will not recover my ability to interact meaningfully with myself and those around me, I want to stop or withhold **all** treatments that might prolong my existence. Treatments I would not want include tube feedings, IV fluids, respirator/ventilator (breathing machine), cardiopulmonary respiration (CPR), kidney dialysis, antibiotics **OR**

I choose to continue treatment. I want all treatments to prolong my life as long as possible within the limits of generally accepted health care standards. *(If you choose this option, please cross through the Living Will Section below to avoid confusion about your instructions.)* **OR**

I choose to provide no written guidelines, directing my agent to make decisions based on my known values and wishes.

**My instructions about pain and symptom control:** *(Initial only ONE box in this section.)*

I want medical treatments and nursing care that will make me comfortable, even if it means I am unable to interact with others. I want treatment for such things as shortness of breath, agitation, and/or seizures. **OR**

I choose to forego pain control measures. **OR**

I choose to provide no written guidelines, directing my agent to make decisions based on my known values and wishes.

**Other instructions or limitations I wish to provide:**  
*(You may include any other instructions, such as withdrawing treatments after a certain amount of time if you are not getting better, or about any medical treatment or about comfort care. You may also include information about organ, tissue or eye donation, religious or cultural considerations, autopsy, etc.)*

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*(Cross through and initial this box if you do not want to make a living will in this form)*

**“Living Will” portion of advance medical directive**

If at any time my physician should determine that I have a **terminal\*** condition, where life-prolonging treatment would serve only to artificially prolong my death, I direct that all life-prolonging treatments be withheld or withdrawn, and that I be allowed to die naturally. I will continue to receive pain medication and any operation or other care needed to reduce pain or make me more comfortable. [\*Terminal means either (1) it is reasonably probable that I cannot recover and my death will occur very soon or (2) I am in a “persistent vegetative state” or permanently unconscious.]

OPTION: I specifically direct that the following procedures or treatments be provided to me.

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This advance directive shall not terminate in the event of my disability. A copy of this document may be provided to any physician or institution providing care for me. By signing below, I indicate that I am emotionally and mentally competent to make this advance directive and that I understand the purpose and effect of this document.

Date \_\_\_\_\_ Signature \_\_\_\_\_  
Witness \_\_\_\_\_ Witness \_\_\_\_\_

*(Witnesses must be an adult and may not be your blood relative or spouse)*