VIRGINIA ADVANCE DIRECTIVE FOR HEALTH CARE, WITH SPECIFIC INSTRUCTIONS FOR MENTAL HEALTH CARE AND OTHER TREATMENT

I, _____, hereby make known my wishes if I am incapable of making an informed decision about my health care, as follows:

(You may include any or all of the provisions in Sections I and II below.)

SECTION I: APPOINTMENT AND POWERS OF MY AGENT

[Cross through this entire Section I if you do not want to appoint an agent to make health care decisions for you.]

A. Appointment of My Agent

I hereby appoint:

Name of Primary Agent: _____

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

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

Home Address: _____

as my agent to make health care decisions on my behalf as authorized in this document. If the primary agent named above is not reasonably available or is unable or unwilling to act as my agent, then I appoint as successor agent to serve in that capacity:

Name of Successor Agent: _____

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

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

Home Address: _____

I grant to my agent full authority to make health care decisions, including decisions about mental health care, on my behalf as described below. My agent shall have this authority whenever and for as long as I have been determined to be incapable of making an informed decision in accordance with the requirements of the Virginia Health Care Decisions Act (VA Code Section 54.1-2981, et seq). I want my agent to follow my desires and preferences as stated in this document or as otherwise known to him or her. If my agent cannot determine what health care choice I would have made on my own behalf, then I want my agent to make a choice for me based upon what he or she believes to be in my best interests. I want my agent and health care providers to use their best efforts to communicate with me about my care and to seek and consider my views and preferences.

B. Powers of My Agent

[If you appointed an agent above, you may give him/her the powers listed below. You may cross through any powers listed below that you do not want to give your agent and add any additional powers you do want to give your agent.]

The powers of my agent shall include the following:

1. To consent to or refuse or withdraw consent to any type of health care, including, but not limited to, artificial respiration (breathing machine), artificially administered nutrition (tube feeding) and hydration (IV fluids), and cardiopulmonary resuscitation (CPR). This authorization specifically includes the power to consent to dosages of pain-relieving medication in excess of recommended dosages in an amount sufficient to relieve pain. This applies even if this medication carries the risk of addiction or of inadvertently hastening my death.
2. 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 as necessary to carry out my directions as stated in this advance directive.
3. To employ and discharge my health care providers.
4. To authorize my admission, transfer, or discharge to or from a hospital, hospice, nursing home, assisted living facility or other health care facility.
5. To authorize my admission to a health care facility for treatment of mental illness for up to ten (10) calendar days, as the law now permits, and for such period of time as may be permitted by law in the future.
6. To continue to serve as my agent even if I object to the agent's authority after I have been determined to be incapable of making an informed decision.
7. 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.
8. 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 that aims to increase scientific understanding of any condition that I may have or otherwise to promote human well-being, even though it offers no prospect of direct benefit to me.
9. To make decisions regarding visitation during any time that I am admitted to any health care facility, consistent with the specific directions I have provided in Section II below.
10. To take any lawful actions that may be necessary to carry out these decisions, including the granting of releases of liability to medical providers.

ADDITIONAL POWERS, IF ANY:

C. Special Powers of My Agent to Authorize Health Care Over My Objection

[This part of Section I allows you to authorize your health care agent to consent to treatment recommended by your physician even if you are objecting at that time because of the effects of mental disorder. If you do not want to give your agent this authority, you should skip this subsection or cross through it. If you do want to give your agent this authority, you should check and initial the boxes next to the special powers you want to give your agent. However, these instructions will not be legally binding unless a physician or clinical psychologist certifies that you understand the consequences of giving your agent these special powers.]

If I have been found to be incapable of making informed decisions about my health care and I am objecting to health care that my agent and my physician believe I need, my agent shall have the following additional power(s):

☐ _____ 1. To authorize my admission to a health care facility for the treatment of mental illness as permitted by law, even if I object.

☐ _____ 2. To authorize other health care that is permitted by law and that my health care agent and my physician believe I need, even if I object. This would include all health care with the exception of the types of health care I have written in the space below or elsewhere in this document:

I do **not** authorize my agent to allow the following specific types of health care over my objection:

[To give your agent any of the powers set forth in this subsection C, a physician or licensed clinical psychologist who knows you must sign the statement in the box below.]

I am a physician/licensed clinical psychologist 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.

_____

Physician or Licensed Clinical Psychologist Signature Date

_____

Physician or Licensed Clinical Psychologist Printed Name and Address

SECTION II: MY HEALTH CARE PREFERENCES AND INSTRUCTIONS

This section of my Advance Directive for Health Care sets forth my preferences and instructions regarding my health care. Any health care agent that I have appointed, and any treatment providers working with me, are directed to provide care consistent with my stated instructions and preferences to the extent possible unless they are medically or ethically inappropriate or are contrary to law. I understand that it is important for me to review and update this document periodically, so that it fairly reflects my condition, my needs, and my values and preferences, and to make sure that my treatment providers and my agent have a copy of my Advance Directive.

[You may use any or all of Parts A-G in this section to direct your health care even if you do not name an agent. If you choose <u>not</u> to provide written instructions, health care decisions will be based on your values and preferences, if known, or, if your values and preferences are not known, on your best interests. You do not need to complete every part of this section. Just skip over or cross out any parts that you do not want to fill out.]

A. My Health Conditions and Current Treatments

[This part gives you an opportunity to provide background information to your treatment providers. It includes no instructions. You do not have to fill it out.]

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

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

3. My medications and dosages as of ____/____/20___ (or use this space to show where people can get updated information about your medications):

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

B. Information Sharing and Emergency Contacts

I understand that the information in this document may be shared by my health care provider with any other health care provider who may serve me, when doing so is necessary to provide treatment in accordance with this advance directive. My current providers, who have information to help with my care, are:

Primary Care Physician: _____

Work Phone #_____

Other Treatment Provider: _____

Work Phone #_____

In case of health crisis, including admission to a 24-hour mental health facility, I authorize the health care providers and other people helping me to contact my health care agent **and** the following other people to share information about my location, condition and needs if they believe that doing so is in my best interests:

Name:_____

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

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

Home Address:_____

Relationship to Me: _____

Name:_____

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

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

Home Address:_____

Relationship to Me: _____

C. Medication

[This part allows you to state your preferences regarding use of medications if you become unable to make informed decisions to consent or refuse. You may refer to specific medications or classes of medications.]

1. Medication Preferences.

[Your physician is obligated to consider your preferences, but must base medication decisions on his or her clinical judgment about your treatment needs, and is not required to follow instructions that are medically or ethically inappropriate.]

I prefer that the following medications or classes or types of medication be tried <u>first</u> in a crisis or emergency:

Medication or class of medications #1:

For treatment of the following problem or condition:

Reason I prefer this medication:

Medication or class of medications #2:

For treatment of the following problem or condition:

Reason I prefer this medication:

Medication or class of medications #3:

For treatment of the following problem or condition:

Reason I prefer this medication:

2. Medication Authorization and Refusal.

[In general, your agent cannot authorize, and your physician cannot order, administration of the medications that you refuse below except in narrow circumstances permitted by law, such as emergencies.]

I consent, or authorize my agent to consent, to administration of medications my treating physician deems appropriate, with the exception of the medications listed below (or their respective brand-name, trade-name, or generic equivalents) or classes of medication which I specifically do **not** authorize. I realize that my condition and needs may change, and that medications may change. So, for each medication listed, I also state whether my agent can authorize use of the medication if my physician finds, and my agent agrees, that the medication is clearly the most appropriate treatment for me under the circumstances.

Medication or class of medications #1:

Reason I refuse this medication:

Agent may authorize this medication if necessary: Yes ☐ No ☐

Medication or class of medications #2:

Reason I refuse this medication:

Agent may authorize this medication if necessary: Yes ☐ No ☐

Medication or class of medications #3:

Reason I refuse this medication:

Agent may authorize this medication if necessary: Yes ☐ No ☐

3. Additional preferences about medications:

D. Mental Health Crisis Intervention

[This part allows you to provide information about your condition and your preferences to help your agent and treatment providers meet your needs in a mental health crisis. Your health care providers will 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.]

1. My Past Experience

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

b. Interventions that may help 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:

3. My preferences regarding behavioral emergency interventions: If I am in immediate danger of harming myself or other people, I prefer that emergency interventions be tried in the following order if they are medically necessary *[RANK THE CHOICES BELOW IN ORDER OF YOUR PREFERENCE FROM 1 TO 4.]*

____ Medication in pill or liquid form
____ Physical Restraint
____ Medication by Injection
____ Seclusion

Reasons for my preferred order:

☐ I have had a traumatic experience in my past that makes seclusion and restraint particularly stressful and thus inappropriate for me.

E. Other Health Care Instructions

1. In General

2. Visitation

a. I give permission for the following people to visit me in the hospital or crisis unit:

b. I do not give permission for the following people to visit me in the hospital or crisis unit:

3. Electroconvulsive therapy ***[Check one box and initial either A or B.]***:

☐ _____A. I do not consent to the administration of electroconvulsive therapy.

OR

☐ _____ B. I authorize my agent to consent to the administration of electroconvulsive therapy if clinically indicated.

F. Life Management Instructions.

[When a person is hospitalized without an opportunity to make specific plans beforehand, many problems can arise. This subsection allows you to express your wishes if you have not done so elsewhere. Although expressing your wishes could be very useful, these statements do not necessarily have any legal effect.]

☐ _____ I am not completing this section because I already have a crisis plan. How to find that crisis plan:

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), the following person is my first choice to care for them:

Name:_____ Relationship:_____

Address:_____

Phone No. (Home):_____ Cell:_____

Phone No. (Work): _____ Email: _____

G. Life-Prolonging Treatment

[This subsection of the advance directive allows you to express your preferences or instructions about your health care if your death is imminent (very soon) or your brain becomes severely and permanently damaged. You do not have to make any specific decisions about these issues. If you have appointed a health care agent, he or she can make specific decisions for you at the appropriate time. If you are not sure about your preferences, discuss your feelings and thoughts with your health care agent, your doctors and/or other people who care about you.]

1. I provide the following instructions if my attending physician determines that my death is imminent (very close) and medical treatment will not help me recover:

[Check only 1 box and initial the accompanying line.]

☐ _____ 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. (OR)

☐ _____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. (OR)

☐ _____ ***[You may write here your own preferences and instructions about your care when you are dying, including specific instructions about treatments that you <u>do</u> want, if medically appropriate, or <u>do not</u> want. It is important that any instructions you give here do not conflict with other instructions you have given in this advance directive.]***

2. I provide the following instructions 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.

[Check only 1 box and initial on the accompanying line.]

☐ _____ 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. (OR)

☐ _____ 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. (OR)

☐ _____ 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. (OR)

☐ _____ ***[You may write here your preferences and instructions about your care when you are unable to interact with others and are not expected to recover this ability. This includes specific instructions about treatments you <u>do</u> want, if medically appropriate, or <u>do not</u> want. It is important that any instructions you give here do not conflict with other instructions you have given in this advance directive.]***

SECTION III: ANATOMICAL GIFTS

[You may use this document to record your decision to donate your organs, eyes and tissues or your whole body after your death. If you do not make this decision here or in any other document, your agent can make the decision for you, unless you specifically prohibit him/her from doing so, which you may do in this or some other document. Check one of the boxes below if you wish to use this section to make your donation decision.]

☐ 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. I understand that I may register my directions at the Department of Motor Vehicles or directly on the donor registry, www. DonateLifeVirginia.org, and that I may use the donor registry to amend or revoke my directions; OR

☐ I donate my whole body for research and education.

[Write here any specific instructions you wish to give about anatomical gifts.]

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AFFIRMATION AND RIGHT TO REVOKE: By signing below, I indicate that I understand this document and that I am willingly and voluntarily executing it. I also understand that I may revoke all or any part of it at any time as provided by law.

_____

Date Signature of Declarant

The declarant signed the foregoing advance directive in my presence. [***Two adult witnesses needed***]

_____

Witness Signature Witness Printed

_____

Witness Signature Witness Printed

This form satisfies 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. It is your responsibility to provide a copy of your advance medical directive to your treating physician. You also should provide copies to your agent, close relatives and/or friends.