VIRGINIA
Advance Directive
Planning for Important Healthcare Decisions

Courtesy of CaringInfo
www.caringinfo.org
800-658-8898

CaringInfo, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care and the experience of caregiving during serious illness and at the end of life. As part of that effort, CaringInfo provides detailed guidance for completing advance directive forms in all 50 states, the District of Columbia, and Puerto Rico.

This package includes:

- Instructions for preparing your advance directive. Please read all the instructions.
- Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

BEFORE YOU BEGIN

Check to be sure that you have the materials for each state in which you may receive healthcare. Because documents are state-specific, having a state-specific document for each state where you may spend significant time can be beneficial. A new advance directive is not necessary for ordinary travel into other states. The advance directives in this package will be legally binding only if the person completing them is a competent adult who is 18 years of age or older, or an emancipated minor.

ACTION STEPS

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.

2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.

3. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.

4. Once the form is completed and signed, photocopy, scan, or take a photo of the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, healthcare providers, and/or faith leaders so that the form is available in the event of an emergency.

5. You may also want to save a copy of your form in your electronic healthcare record, or an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

6. Virginia maintains an Advance Directive Registry. By filing your advance directive with the registry, your health care provider and loved ones may be able to find a copy of your directive in the event you are unable to provide one. You can read more about the registry, including instructions on how to file your advance directive, at https://www.connectvirginia.org/adr/.

INTRODUCTION TO YOUR VIRGINIA ADVANCE HEALTH CARE DIRECTIVE

This packet contains a **Virginia Advance Directive**, which protects your right to refuse medical treatment you do not want or to request treatment you do want in the event you lose the ability to make decisions yourself.

Part I, **Appointment and Powers of My Agent**, lets you name an adult, your "agent," to make decisions about your health care—including decisions about life- prolonging procedures—if you can no longer speak for yourself. **Part II**, **My Health Care Instructions**, lets you state your wishes about health care in the event you cannot speak for yourself, including if you develop a terminal condition or you are in a persistent vegetative state. If you are an organ, eye or tissue donor, your instructions will be applied so as to ensure the medical suitability of your organs, eyes and tissues for donation. **Part III** allows you to record your organ and tissue donation wishes. **Part IV** contains the signature and witnessing provisions so that your document will be effective.

You may complete Part I, Part II, Part III, or all parts, depending on your advance-planning needs. **You must complete Part IV**.

How do I make my Virginia Advance Health Care Directive legal?

You must sign your advance directive in the presence of two adult witnesses. Any person over the age of 18—including a spouse, other relative, or health care provider—can witness your Virginia Advance Directive.

Whom should I appoint as my agent?

Your agent is the person you appoint to make decisions about your healthcare if you become unable to make those decisions yourself. Your agent may be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making healthcare decisions for you.

Should I add personal instructions to my advance directive?

Yes! One of the most important reasons to execute an advance directive is to have your voice heard. When you name an agent and clearly communicate to them what you want and don't want, they are in the strongest position to advocate for you. Because the future is unpredictable, be careful that you do not unintentionally restrict your agent's power to act in your best interest. Be especially careful with the words "always" and "never." In any event, be sure to talk with your agent and others about your future healthcare and describe what you consider to be an acceptable "quality of life."

When does my agent's authority become effective?

Part I, **Appointment and Powers of My Agent**, goes into effect when your doctor and one other qualified doctor or clinical psychologist certify in writing that you are incapable of making an informed decision regarding health care.

Part II, **My Health Care Instructions**, goes into effect when your doctor and one other qualified doctor or clinical psychologist certify in writing that you are incapable of making an informed decision regarding health care and a condition you have given instructions for arises.

Agent Limitations

Your agent does **not** have the authority to consent to nontherapeutic sterilization, abortion, or psychosurgery.

Your agent will be bound by the current laws of Virginia as they regard pregnancy and termination of pregnancies.

What if I change my mind?

You may revoke your Virginia Advance Directive at any time by:

- signing and dating a written revocation,
- physically cancelling or destroying your document, or directing another to do so in your presence, or
- orally expressing your intent to revoke the document.

Your revocation becomes effective when you notify your attending physician.

Also, make certain that you file any updates or changes to your Virginia Advance Directive with the Virginia registry.

Mental Health Issues

These forms do not *expressly* address mental illness, although you can state your wishes and grant authority to your agent regarding mental health issues. The National Resource Center on Psychiatric Advance Directives maintains a website (https://nrc-pad.org/) with links to each state's psychiatric advance directive forms. If you would like to make more detailed advance

care plans regarding mental illness, you could talk to your physician and an attorney about a durable power of attorney tailored to your needs.

What other important facts should I know?

You may expressly provide in your Advance Directive that, in the event you are incapable of making an informed health care decision, your agent may authorize or withhold health care over your objection. In order for this provision to be effective, the following must occur:

1. You must name an agent in your Advance Directive;
2. You must specify the treatments to which this provision applies;
3. Your physician or licensed clinical psychologist must attest in writing at the time your Advance Directive is made that you are capable of making an informed decision and understand the consequences of the provision;
4. The health care decision does not involve withholding or withdrawing life-prolonging procedures; and
5. The health care that is to be provided, continued, withheld or withdrawn is determined and documented by your attending physician to be medically appropriate and is otherwise permitted by law.

If you decide to include language regarding care given over your objection, you may wish to speak with your health care provider or an attorney with experience in drafting advance directives regarding this language. Any such language may be included in Part I, No. 11 of your Virginia Advance Directive.

Be aware that your advance directive will not be effective in the event of a medical emergency, except to identify your agent. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless you have a separate physician's order, which are typically called "prehospital medical care directives" or "do not resuscitate orders." DNR forms may be obtained from your state health department or department of aging (https://www.hhs.gov/aging/state-resources/index.html). Another form of orders regarding CPR and other treatments are state-specific POLST (portable orders for life sustaining treatment) (https://polst.org/form-patients/). Both a POLST and a DNR form MUST be signed by a healthcare provider and MUST be presented to the emergency responders when they arrive. These directives instruct ambulance and hospital emergency personnel not to attempt CPR (or to stop it if it has begun) if your heart or breathing should stop.

Virginia Advance Directive

PRINT YOUR NAME

I, _____,
willingly and voluntarily make known my wishes in the event that I am incapable of making an informed decision about my health care, as follows in this document.

This advance directive shall not terminate in the event of my disability.

PART I: APPOINTMENT OF AGENT

(CROSS THROUGH AND INITIAL IF YOU DO NOT WANT TO APPOINT AN AGENT TO MAKE HEALTH CARE DECISIONS FOR YOU)

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR PRIMARY AGENT

I hereby appoint _____,
(primary agent)
of _____

_____
(address and telephone number)

as my agent to make health care decisions on my behalf as authorized in this document. If the person I have appointed above is not reasonably available or is unable or unwilling to act as my agent, then I appoint

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR ALTERNATE AGENT

_____,
(alternate agent)
of _____

_____,
(address and telephone number)
to serve in that capacity.

I grant to my agent, named above, full power and authority to make health care decisions on my behalf, as described below, whenever I have been determined to be incapable of making an informed decision. My agent's authority hereunder is effective as long as I am incapable of making an informed decision.

In making health care decisions on my behalf, 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.

POWERS OF MY AGENT
(CROSS THROUGH AND INITIAL ANY LANGUAGE YOU DO NOT WANT AND ADD ANY LANGUAGE YOU DO WANT)

POWERS OF YOUR AGENT

CROSS THROUGH AND INITIAL ANY LANGUAGE YOU DO NOT WANT AND ADD ANY LANGUAGE YOU DO WANT

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 medical care facility.

5. To authorize my admission to a health care facility for treatment of mental illness as permitted by law. (If I have other instructions for my agent regarding treatment for mental illness, they are stated in a supplemental document.)

6. To continue to serve as my agent 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.

POWERS OF YOUR AGENT (continued)

9. To make decisions regarding visitation during any time that I am admitted to any health care facility, consistent with the following directions: _____

11. Additional powers or limitations, if any:

PRINT ANY ADDITIONAL POWERS YOU WANT YOUR AGENT TO HAVE OR ANY LIMITATIONS ON THE POWERS OF YOUR AGENT, IF ANY

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

I give the following instructions to further guide my agent in making health care decisions for me:

(attach additional pages if needed)

PART II: HEALTH CARE INSTRUCTIONS

[YOU MAY USE ANY OR ALL OF PARTS A, B, OR C IN THIS SECTION TO DIRECT YOUR HEALTH CARE EVEN IF YOU DO NOT HAVE AN AGENT. IF YOU CHOOSE NOT TO PROVIDE WRITTEN INSTRUCTIONS, DECISIONS WILL BE BASED ON YOUR VALUES AND WISHES, IF KNOWN, AND OTHERWISE ON YOUR BEST INTERESTS. IF YOU ARE AN ORGAN, EYE OR TISSUE DONOR, YOUR INSTRUCTIONS WILL BE APPLIED SO AS TO ENSURE THE MEDICAL SUITABILITY OF YOUR ORGANS, EYES AND TISSUES FOR DONATION.]

A. Instructions If I have a Terminal Condition

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

INITIAL ONLY ONE

YOU MAY WRITE HERE YOUR OWN INSTRUCTIONS ABOUT YOUR CARE WHEN YOU ARE DYING, INCLUDING SPECIFIC INSTRUCTIONS ABOUT TREATMENTS THAT YOU DO WANT, IF MEDICALLY APPROPRIATE, OR DON'T WANT.

IT IS IMPORTANT THAT YOUR INSTRUCTIONS HERE DO NOT CONFLICT WITH OTHER INSTRUCTIONS YOU HAVE GIVEN IN THIS ADVANCE DIRECTIVE

ATTACH ADDITIONAL PAGES IF NEEDED

_____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 direct the following regarding health care when I am dying:

B. Instructions if I am in a Persistent Vegetative State

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:

INITIAL ONLY ONE

YOU MAY WRITE HERE YOUR 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 DO WANT, IF MEDICALLY APPROPRIATE, OR DON'T WANT. IT IS IMPORTANT THAT YOUR

INSTRUCTIONS HERE DO NOT CONFLICT WITH OTHER INSTRUCTIONS YOU HAVE GIVEN IN THIS ADVANCE DIRECTIVE

ATTACH ADDITIONAL PAGES IF NEEDED

_____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 _____(insert time period) as the period of time, after which such treatment should be stopped if my condition has not improved. The exact time period is at the discretion of my agent or surrogate in consultation with my physician. I understand that I still will receive treatment to relieve pain and make me comfortable.

OR

____I direct the following regarding when I am 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:

_____
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_____

YOU MAY WRITE HERE STATEMENTS AND INSTRUCTIONS ABOUT TREATMENTS THAT YOU DO WANT, IF MEDICALLY APPROPRIATE, OR ABOUT TREATMENTS YOU DO NOT WANT UNDER SPECIFIC CIRCUMSTANCES OR ANY CIRCUMSTANCES.

IT IS IMPORTANT YOUR INSTRUCTIONS HERE DO NOT CONFLICT WITH OTHER INSTRUCTIONS YOU HAVE GIVEN IN THIS ADVANCE DIRECTIVE

THESE INSTRUCTIONS CAN ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

C. Other Instructions Regarding My Health Care

I further direct the following regarding my health care when I am incapable of making my own health care decisions:

(attach additional pages if needed)

PART III: ORGAN DONATION

[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.]

IF YOU WISH TO DONATE YOUR ORGANS, EYES, OR TISSUES, INITIAL THE OPTION THAT REFLECTS YOUR WISHES

_____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.

INSERT ANY SPECIFIC INSTRUCTIONS YOU WISH TO GIVE ABOUT ANATOMICAL GIFTS, IF ANY

ATTACH ADDITIONAL PAGES IF NECESSARY

I direct the following regarding donation of my organs, eyes, and tissues:

PART IV: EXECUTION

Affirmation and Right to Revoke: By signing below, I indicate that I am emotionally and mentally capable of making this advance directive and that I understand the purpose and effect of this document. I understand I may revoke all or any part of this document at any time.

SIGN, DATE, AND PRINT YOUR NAME HERE

_____

(signature of declarant) (date)

_____

(printed name)

The declarant signed the foregoing advance directive in my presence.

YOUR TWO WITNESSES MUST SIGN, DATE, AND PRINT THEIR NAMES HERE

Witness Signature _____ Date_____

Printed name _____

Witness Signature _____ Date_____

Printed name _____

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