Virginia Advance Health Care Directive

On this date of _____ , I, _____ , do hereby sign, execute, and adopt the following as my Advance Health Care Directive. I direct any and all persons or entities involved with my health care in any manner that these decisions are my wishes and were adopted without duress or force and of my own free will.

I have placed my initials next to the sections of this Directive that I have adopted:

[ ] Living Will
[ ] Appointment of Health Care Agent
[ ] Designation of Primary Physician
[ ] Organ Donation

Living Will

I, willfully and voluntarily make known my desire and do hereby declare: If at any time my attending physician should determine that I have a terminal condition where the application of life-prolonging procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

I specifically direct that the following procedures or treatments be provided to me (*optional*):

In the absence of my ability to give directions regarding the use of such life-prolonging procedures, it is my intention that this advance directive shall be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences of such refusal.

Appointment of Health Care Agent

(Cross through if you do not want to appoint an agent to make health care decisions for you.)

I hereby appoint _____ (name), of _____ (address), as my agent to make health care decisions on my behalf as authorized in this document.

OPTIONAL - DESIGNATION OF ALTERNATE AGENT: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my alternate agent

_____ (name of individual you choose as alternate agent)
_____ (address)

I hereby 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 about providing, withholding, or withdrawing medical treatment. The phrase "incapable of making an informed decision" means being unable to understand the nature, extent, and probable consequences of a proposed medical decision or unable to make a rational evaluation of the risks and benefits of a proposed medical decision as compared with the risks and benefits of alternatives to that decision, or unable to communicate such understanding in any way. My agent's authority hereunder is effective as long as I am incapable of making an informed decision.

The determination that I am incapable of making an informed decision shall be made by my attending physician and a second physician or licensed clinical psychologist after a personal examination of me and shall be certified in writing. Such certification shall be required before treatment is withheld or withdrawn, and before, or as soon as reasonably practicable after, treatment is provided, and every one-hundred-eighty (180) days thereafter while the treatment continues.

In exercising the power to make health care decisions on my behalf, my agent shall follow my desires and preferences as stated in this document or as otherwise known to my agent. My agent shall be guided by my medical diagnosis and prognosis and any information provided by my physicians as to the intrusiveness, pain, risks, and side effects associated with treatment or non-treatment. My agent shall not authorize a course of treatment which he or she knows, or upon reasonable inquiry ought to know, is contrary to my religious beliefs or my basic values, whether expressed orally or in writing. If my agent cannot determine what treatment choice I would have made on my own behalf, then my agent shall make a choice for me based upon what he or she believes to be in my best interests.

POWERS OF MY AGENT **(optional) (Cross through 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, 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, artificially-administered nutrition and hydration, and cardiopulmonary resuscitation. This authorization specifically includes the power to consent to the administration of dosages of pain-relieving medication in excess of recommended dosages in an amount sufficient to relieve pain, even if such medication carries the risk of addiction or inadvertently hastens my death, (2) To request, receive, and review any information, verbal or written, regarding my physical or mental health, including but not limited to, medical and hospital records, and to consent to the disclosure of this information, (3) To employ and discharge my health care providers, (4) To authorize my admission to or discharge (including transfer to another facility) from any hospital, hospice, nursing home, adult home, or other medical care facility for services other than those for treatment of mental illness requiring admission procedures provided in Article 1 (§ 37.1-63 et seq.) of Chapter 2 of Title 37.1, and (5) To take any lawful actions that may be necessary to carry out these decisions, including the granting of releases of liability to medical providers.

Further, my agent shall not be liable for the costs of treatment pursuant to his or her authorization, based solely on that authorization. This advance directive shall not terminate in the event of my disability.

Designation of Primary Physician

I designate the following physician as my primary physician: _____ (name)
_____ (address)
_____(phone).

OPTIONAL- DESIGNATION OF ALTERNATE PRIMARY PHYSICIAN: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:
_____ (name)
_____ (address)
_____(phone).

Organ Donation

In the event of my death, I have placed my initials next to the following part(s) of my body that I wish donated for the purposes **that I have initialed below:**

[ ] any organs or parts **OR**

[ ] eyes	[ ] bone and connective tissue	[ ] skin
[ ] heart	[ ] kidney(s)	[ ] liver
[ ] lung(s)	[ ] pancreas	[ ] other _____

for the purposes of:

[ ] any purpose authorized by law **OR**

[ ] transplantation	[ ] research	[ ] therapy
[ ] medical education	[ ] other limitations _____	

Signature

I sign this Advance Health Care Directive, consisting of the following sections, **which I have initialed below and have elected to adopt:**

[ ] Living Will
[ ] Appointment of Health Care Agent
[ ] Designation of Primary Physician
[ ] Organ Donation

BY SIGNING HERE I INDICATE THAT I UNDERSTAND THE PURPOSE AND EFFECT OF THIS DOCUMENT.

Signature _____ Date _____

City, County, and State of Residence _____

Notary Acknowledgment

State of _____
County of _____

On _____ , _____ came before me personally and, under oath, stated that he or she is the person described in the above document and he or she signed the above document in my presence. I declare under penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

_____
Notary Public
My commission expires _____

Witness Acknowledgment

The declarant is personally known to me and I believe him or her to be of sound mind and under no duress, fraud, or undue influence. I did not sign the declarant's signature above for or at the direction of the declarant and I am not appointed as the health care agent or attorney-in-fact herein. I am at least eighteen (18) years of age and I am not related to the declarant by blood, adoption, or marriage, entitled to any portion of the estate of the declarant according to the laws of intestate succession or under any will of declarant or codicil thereto, or directly financially responsible for declarant's medical care. I am not a health care provider of the declarant or an employee of the health facility in which the declarant is a patient.

Witness Signature _____ Date _____

Printed Name of Witness _____

Second Witness Signature _____ Date _____

Printed Name of Second Witness _____

Acceptance of Health Care Agent

I accept my appointment as Health Care Agent:

Signature _____ Date _____

I accept my appointment Alternate Health Care Agent:

Signature _____ Date _____