



1500001

PLEASE WRITE YOUR NAME AND HOSPITAL MEDICAL RECORD NUMBER (IF KNOWN)

VIRGINIA ADVANCE MEDICAL DIRECTIVE SHORT VERSION FOR APPOINTMENT OF AGENT ONLY

Brief Explanation – For more information see “Talking About Your Health Care Choices”, PE 18044

- You have the right to name someone to make health care decisions for you if you are unable to make them for yourself.
- You have the right to give instructions about what types of health care you want or do not want.
- You may use this shortened form to name an agent. The complete form is available to provide specific information or you may attach a letter or other information about your values, goals, or wishes.
- Check each of the boxes after the agent box acknowledging you have read and understand the information.
- To be legal, this form must be signed, dated, and have two adults witness your signature.

I, _____, willingly and voluntarily make known my wishes in the event that I am incapable of making an informed decision.
 (Please print first, middle, last name.)

You may complete any or all of the sections and add comments. Cross off and initial anything that does not apply to your wishes. Use the blank space on the last page to give more details.

Section 1: APPOINTMENT OF AN AGENT FOR HEALTH CARE DECISIONS

I hereby appoint the following as my primary agent to make health care decisions on my behalf as authorized in this document: (please print)

Primary agent name _____ Day/cell phone _____
 Address _____ Evening phone _____
 Email: _____ Relationship to patient _____

If my primary agent is not reasonably available or is unable or unwilling to make health care decisions for me, I appoint the following person as my substitute agent.

Substitute agent _____ Day/cell phone _____
 Address _____ Evening phone _____
 Email: _____ Relationship to patient _____

I wish to give my agent all the powers possible under Virginia law, shown on Page 2. My agent shall make decisions following my desires and preferences, guided by information from my health care providers. Decisions shall be made based on my religious beliefs or my basic values. If it not known what choice I would have made, if able, decisions shall be made based on what is believed to be in my best interests.

I have been given the opportunity to read information about Advance Directives and ask questions.

A copy of this advance directive may be provided to any physician or institution treating me. 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 that I may revoke all or part of the document at any time by destroying this form or creating a new advance directive.

I have provided health care instructions on page 2.

Signature _____ Date _____

Address _____ Date of Birth _____

I have seen this person sign the advance directive in my presence.

Witness _____ Witness _____

(Witnesses must be adults. We suggest that they not be the persons you are appointing as your agents for health care decisions.)

TREATMENT:

- A. **To consent to, or refuse or withdraw consent to**, any type of health 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 an amount sufficient to relieve pain, even if such medication carries the risk of addiction or inadvertently hastening my death or is in excess of commonly recommended dosages;

HEALTH RECORDS AND PROVIDERS

- B. **To request, receive and review any information** (whether verbal, written, printed or electronically recorded) regarding my current physical or mental health, including but not limited to medical, hospital and other records; and to consent to the disclosure of such information for medical or insurance purposes;
- C. **To employ and discharge** my health care providers;

ADMISSION and DISCHARGE

- D. To authorize my **admission to or discharge from** any hospital, hospice, nursing home, assisted living facility or other **medical care** facility.
- E. To authorize my **admission** to a health care facility for the treatment of **mental illness** as permitted by law. (More details may be provided in a supplemental document.)

RESEARCH

- F. To authorize my participation in any health care study approved by an institutional review board or research review committee if the study **offers the prospect of direct therapeutic benefit to me.**
- G. To authorize my participation in any health care study approved by an institutional review board or research review committee that aims to increase scientific understanding of any condition that I may have or otherwise to promote human well-being, even though the study **offers no prospect of direct benefit to me.**

VISITATION

- H. To make decisions about **who may visit me**, subject to physician orders and policies of any institution to which I am admitted. (More details may be provided in a supplemental document.)

OTHER POWERS

- I. **To continue to serve as my agent even if I protest** the agent's authority after I have been determined to be incapable of making an informed decision; (If incapacitated patients at UVA protest their agent's authority, we will involve our Ethics Consult Service.)
- J. To take any **lawful actions** that may be necessary to carry out these decisions, including the granting of releases of liability to medical providers.

Section II: MY HEALTH CARE INSTRUCTIONS:

Below are guidelines for my agent about my treatment choices (may include: care you want to receive if medically appropriate; care you do not want to receive; and/or other information including organ, tissue, eye donation; autopsy; location of other documents):

For more information about:

Advance Directives in Virginia please contact a UVA Social Worker or visit the website: www.virginiaregistry.org

Organ, tissue, or eye donation, call LifeNet at 1-800-847-7831 or visit www.save7lives.org

Donating your body to science call State Anatomical Program at 1-804-786-2479.