Virginia Advance Medical Directive

Virginia Cancer Specialists

In case I ever become unable to make an informed decision about my medical care, I wish to make the following known in advance:

I, _____, voluntarily make known my wishes:

1. APPOINTMENT OF AN AGENT FOR HEALTH CARE DECISIONS

(Medical Power of Attorney)

I appoint the following as my **primary agent** to make health care decisions for me **if there ever comes a time when I cannot make decisions for myself:**

Name: _____ Day Phone: _____

Address: _____ Cell Phone: _____

City: _____ __ **State:** ____ Zip: _____ Email: _____

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

Name: _____ Day Phone: _____

Address: _____ Cell Phone: _____

City: _____ __ **State:** ____ Zip: _____ Email: _____

I want the person I have appointed to be guided by my preferences as stated in this document in making health care decisions.

---

2. INSTRUCTIONS ABOUT END OF LIFE CARE

INSTRUCTIONS: *Checking the boxes below will help to guide your healthcare when you are unable to discuss your wishes. If you do not wish to check the sections below or provide written instructions about your preferences, decisions will be made based on your values and wishes, if known, and otherwise in your best interests.*

A. If I Were Dying:

(Check only 1 box.)

- ☐ If at any time my attending physician should determine that I have a terminal condition where the application of life-prolonging procedures – including artificial respiration, cardiopulmonary resuscitation, artificially administered nutrition and artificially administered hydration – would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me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 want all treatments to prolong my life as long as possible within the limits of generally accepted health care standards.

Other wishes:

_____

_____

_____

_____

B. <u>If I Were In A Persistent Coma Or Had Severe And Permanent Brain Damage:</u>
(Check only 1 box.)

- ☐ I do not want treatments to prolong my life. This includes tube feedings, IV fluids, Cardiopulmonary Resuscitation (CPR), ventilator support (breathing machine), kidney dialysis, or antibiotics. I understand that I will receive treatment to maintain my comfort.
- ☐ 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 maintain my comfort.

What else would you like us to know about your wishes for medical care?

_____

_____

_____

_____

_____

You may include additional pages of information about your wishes for medical care. If so, place the number of additional pages included here: _____

4. SIGNATURES:

By signing below, I show that I understand this document.

Signature: _____ **Date:** _____

Witness: _____ _____
Witness Signature Witness Name Printed

Witness: _____ _____
Witness Signature Witness Name Printed

Other End of Life Requests

If it is possible, when I am nearing my death and cannot speak, I want my friends and family to know I have the following thoughts and feelings:

_____
_____
_____
_____
_____

I want the following at my bedside: (List the type of care, ceremonies, etc. that would make dying more meaningful to you.)

_____
_____
_____
_____

Copies of this document are being or have been given to the following physicians, health care agents, family and friends:

_____
_____
_____
_____
_____

You may cut out below and place in your wallet

NOTICE TO HEALTH CARE PROVIDERS

I, _____ have executed an Advance Medical Directive, dated _____. I have designated the following as my Medical Power of Attorney for Health Care:

_____ _____
Primary Name Phone

_____ _____
Secondary Name Phone

A copy of this document is on file with:

_____ _____
Name Phone

_____
Address

_____ _____ _____
City State Zip

_____ _____
Signature of Declarant Date

Virginia Cancer Specialists

Advance Care Planning
Related Terms and Definitions

Advance Medical Directive
A written document that provides information about what healthcare treatments a person wants. The Advance Directive only becomes effective if a person is incapable of expressing their wishes.

CPR—Cardiopulmonary Resuscitation
A procedure to restart a person's heart and breathing. This includes chest compressions—which squeeze the heart between the sternum and spine, and intubation—which means placement of a tube through the throat and into the trachea to force air into the lungs.

Do Not Resuscitate (DNR) Order
A physician's order, valid during a specific hospital or facility admission, that CPR is not to be started in someone who is dying.

Durable Do Not Resuscitate (DDNR) Order
A legal document, valid anywhere in the Commonwealth of Virginia, which indicates that CPR is not to be initiated. It is signed by both the patient and the physician. (This form is available from Virginia Cancer Specialists.)

Intubation
The placement of a tube through a person's throat into their trachea (windpipe or airway).

Agent for Healthcare Decisions/
Power of Attorney for Health Care
A person appointed to make healthcare decisions when a patient is unable to make decisions for themselves.

Ventilator
A machine which can move air or oxygen into a patient's lungs through an airway tube.