

## VIRGINIA ADVANCE DIRECTIVE FOR HEALTH CARE

I, \_\_\_\_\_, willingly and voluntarily, Printed Name of Individual Making This Advance Directive for Health Care (Declarant) my wishes in the event that 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, II AND III BELOW.)*

### SECTION I: APPOINTMENT AND POWERS OF MY AGENT

*(CROSS THROUGH THIS 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 E-mail Address

\_\_\_\_\_, Home Address Telephone Number

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 an agent to serve in that capacity:

\_\_\_\_\_, Name of Successor Agent E-mail Address

\_\_\_\_\_, Home Address Telephone Number

I grant to my agent full authority to make health care decisions 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 making health care decisions on my behalf, I want my agent to follow my desires and preferences as stated in this document, or otherwise known to him or her. If my agent cannot determine what health care choice I would have made on my own behalf, I want my agent to make a choice for me based upon what he or she believes to be in my best interests.

#### B. Powers of My Agent

*[IF YOU APPOINTED AN AGENT ABOVE, YOU MAY GIVE HIM/HER THE POWERS SUGGESTED BELOW. YOU MAY CROSS THROUGH ANY POWER 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 respiratory (mechanical) ventilation, artificial nutrition (tube feeding) and hydration (IV fluids), and cardiopulmonary resuscitation. Authorization specifically includes the power to consent to dosages of pain-relieving medication in excess of recommended dosages to relieve pain. This applies even if this medication carries the risk of addiction or of inadvertent 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 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 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 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 a 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.