

## Virginia Advance Medical Directive for Health Care Decisions

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State & Zip: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

*Sentara Healthcare Advance Directive Registry Number: 36901001*  
*U.S. Living Will Registry*

This form contains both a "Living Will" and the name of your "Healthcare Agent," and your choices about organ donation or giving your body as a gift to medical science after your death. You may complete any one or all sections of this form. *You must sign this form*, in the presence of two witnesses who are *NOT* blood relatives or your spouse, or someone you are choosing to be your Healthcare Agent. It is up to you, under Virginia law, to give a copy of your Advance Directive to your physicians. You should also give copies of your Advance Directive to close relatives and friends.

**Advance Medical Directive**, made this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

I, \_\_\_\_\_, want the person I have chosen as my *Healthcare Agent*, my physicians, my family and others to follow my wishes as stated below:

### **Part 1: *Section A of My Living Will***

**(Cross through this box if you do not want to make a Living Will in this form)**

*As long as I am able to make my wishes known, my physicians will talk with me and I will make my own decisions about my medical care.* If I am unable to speak for myself and if at any time my attending physician should determine that I have a terminal condition where providing life-prolonging procedures would only artificially prolong my dying, I wish that such procedures be withheld or withdrawn. I direct that I be allowed to die naturally with only the administration of medication or the performance of any medical procedure believed necessary to provide me with comfort care or to ease my pain.

**OPTION:** I specifically wish that the following procedures or treatments be provided to me:

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If I am not able to give directions regarding the use of such life-prolonging procedures it is my wish that this statement be honored by my family and physicians as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences of such refusal.

**Part 1: Section B of My Living Will**

Use this section to describe your wishes regarding treatments that may be offered **if you are in an end-stage or terminal condition or if you have a permanent and severe brain injury with no hope of improvement or recovery.** Your wishes will help the person you have named in Part 2 make decisions for you. This information may also be helpful to your physicians and others who will care for you.

*Put the initials of your name next to your choices.*

**Treatment Choices:**

\_\_\_\_\_ I do not want life-sustaining treatments, such as cardiopulmonary resuscitation (CPR) started. If these treatments are started I want them stopped. (Special Notes: \_\_\_\_\_)

\_\_\_\_\_ I want life-sustaining treatments started on a temporary basis. If I do not show signs of recovery, then I want them stopped. (Special Notes: \_\_\_\_\_)

\_\_\_\_\_ Other wishes regarding life-saving treatments, including dialysis or other major medical treatments:  
\_\_\_\_\_

**Artificial Nutrition and Hydration (food and water by feeding tube or needle):**

\_\_\_\_\_ I do not want a feeding tube started if it would be the main treatment keeping me alive. If a feeding tube is started I want it stopped. (Special Notes: \_\_\_\_\_)

\_\_\_\_\_ I want a feeding tube started on a temporary basis. If I do not show signs of recovery, then I want it stopped. (Special Notes: \_\_\_\_\_)

\_\_\_\_\_ I want artificial nutrition and hydration, even if it is the main treatment keeping me alive. (Special Notes: \_\_\_\_\_)

\_\_\_\_\_ Other wishes regarding artificial nutrition and hydration: \_\_\_\_\_

**Other Directions**

*You have the right to be involved in all decisions about your health care, even those not dealing with an end-stage condition, terminal condition, or a permanent and severe brain injury. If you have wishes not covered in other parts of this document, please write them here:*

\_\_\_\_\_  
\_\_\_\_\_

**Part 2: My Healthcare Agent**

**As long as I am able to make my wishes known, my physicians will talk to me and I will make my own health care decisions.** If there ever comes a time when I can not make health care decisions about myself, I name the following as my *primary Healthcare Agent* to make health care decisions for me as authorized in this document, not to contradict any of my wishes specifically set forth in Part 1:

I give to my Healthcare Agent, named above, full power and authority to make health care decisions for me as described in the Virginia Healthcare Decisions Act, Statute §54.1-2984, whenever I have been determined incapable of making an informed decision about providing, withholding or withdrawing medical treatment.

I further grant to my Agent the power to limit visitation and expressly request they deny visitation especially from:

(Cross through this box if you do not want to appoint a Healthcare Agent in this form)

**Appointment of Primary Agent:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ e-mail address: \_\_\_\_\_

If my primary Healthcare Agent is not reasonably available or is unable or unwilling to act as my Healthcare Agent, I then name the following person as **successor agent** to serve in that capacity:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ e-mail address: \_\_\_\_\_

**Part 3: My Wishes Regarding Anatomical Gift or Organ Donation:**

The following option allows you to give your body to medical science *after your death* or to make a gift of your organs, tissue, or eyes after your death. You may appoint someone to speak for you after your death.

(Cross through this box if you do not want to make an anatomical gift or organ donation on this form)

Upon my death, I direct that an anatomical gift of all of my body or certain organ, tissue or eye donations be made according to my directions, if any, and according to Virginia Law Statute §32.1-290.

(Cross through if you do not want to appoint another person to make an anatomical gift or any organ, tissue, or eye donation for you.)

**OPTION:** Appointment of an agent to make an anatomical gift or organ, tissue, or eye donation.

I appoint (name) \_\_\_\_\_ as my agent to speak for me,  
(address) \_\_\_\_\_

(phone) \_\_\_\_\_, and to make any such anatomical gift or organ, tissue or eye donation after my death. I further direct that: \_\_\_\_\_

**Part 4: Signatures**

**A. Your Signature:**

This Advance Directive shall not stop in the event of my mental or physical disability. By signing below, I state that I am emotionally and mentally capable to make this Advance Directive and that I understand the purpose of this document and require the health care professionals and my family to honor my wishes.

\_\_\_\_\_ Date

\_\_\_\_\_ Your Signature

**B. Your Two Witnesses' Signature**

I believe the person who has signed this Advance Directive to be of sound mind, that he/she signed or acknowledged this Advance Directive in my presence, and that he/she appears not to be acting under pressure, duress, fraud, or undue influence. I am not the spouse or a blood relative of the person making this Advance Directive. I am not the person appointed in this Advance Directive. I am 18 years old or older.

\_\_\_\_\_ PRINT Name : \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_  
(Signature of Witness)

Address \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_ PRINT Name : \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_  
(Signature of Witness)

Address \_\_\_\_\_ Phone \_\_\_\_\_