

## ADVANCE MEDICAL DIRECTIVES

Many people ask for a "Living Will" or a "Medical Power of Attorney". In Virginia, the technical term is actually an "Advance Medical Directive" which, if you think about it, is a more accurate name. You're stating, *in advance*, how much medical care you want when you can't tell anyone or answer their questions. Virginia Code § 54.1-2984 gives a suggested form of written advance directives, but does NOT have to be followed exactly. An advance directive may (i) direct a specific procedure or treatment to be provided, such as artificially administered hydration (water) and nutrition; (ii) direct a specific procedure or treatment to be withheld; or (iii) appoint an agent to make health care decisions if the declarant is determined to be incapable of making an informed decision. It can also include the power to make, after the declarant's death, an anatomical gift of all of the declarant's body, or any organs, tissue or eye donations in compliance with any directions of the declarant. The agent cannot refuse or fail to honor the declarant's wishes in relation to anatomical gifts or organ, tissue or eye donation.

In the form that follows, the person making the Advance Medical Directive is the "Declarant" There is room to name two "Agents", which is people the Declarant trusts to make very important medical decisions. There can be more than two (or only one); the form only has room for two.

**CONTACT YOUR LAWYER IF YOU HAVE QUESTIONS REGARDING THE USE OF THIS FORM. HART & HART ATTORNEYS, LTD. MAKES THIS AVAILABLE ON THE INTERNET FOR CONVENIENCE OF THOSE WHO MIGHT NEED IT, AND ITS USE DOES NOT CREATE OR IMPLY ANY KIND OF ATTORNEY-CLIENT RELATIONSHIP.**

**ADVANCE MEDICAL DIRECTIVE**

I. DECLARATION OF DESIRE AND INTENT:

I, \_\_\_\_\_, (*Declarant*) willfully and voluntarily make known my desire and do hereby declare that 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procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me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:

\_\_\_\_\_

\_\_\_\_\_

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.

II. APPOINTMENT OF AGENT

<i>Primary Agent</i>	<i>Secondary Agent</i>
<i>Name</i>	
<i>Address</i>	
<i>Home Phone</i>	
<i>Work Phone</i>	
<i>Other</i>	

I hereby appoint the "Primary Agent" identified above as my agent to make health care decisions on my behalf as authorized in this document. If the "Primary Agent" is not reasonably available or is unable or unwilling to act as my agent, then I appoint the "Secondary Agent", to serve in that capacity.

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 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 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 nontreatment. My agent shall not authorize a course of treatment which he 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 believes to be in my best interests.

### III POWERS OF MY AGENT *(cross through any language you do not want and add any language you do want.)*

The powers of my agent shall include the following:

- A. To consent to or 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;
- B. 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;
- C. To employ and discharge my health care providers;
- D. 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
- E. 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 authorization whether or not based on that authorization.

IV ANATOMICAL GIFTS *(cross through if you do not want to appoint an agent to make an anatomical gift or any organ, tissue or eye donation for you.)*

Upon my death, I direct that an anatomical gift of all of my body or certain organ, tissue or eye donations may be made pursuant to Article 2 (§ 32.1-289 et seq.) of Chapter 8 of Title 32.1 and in accordance with my directions, if any. I hereby appoint the individuals named above, either of whom may act, as my agent to make any such anatomical gift or organ, tissue or eye donation following my death. I further direct that:

\_\_\_\_\_  
\_\_\_\_\_  
*(declarant's directions concerning anatomical gift or organ, tissue or eye donation).*

**This advance directive shall not terminate in the event of my disability.**

By signing below, I indicate that I am emotionally and mentally competent to make this advance directive and that I understand the purpose and effect of this document.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Declarant Signature

The declarant signed the foregoing advance directive in my presence. I am not the spouse or a blood relative of the declarant.

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Witness Printed Name And Address

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Witness Printed Name And Address