Sentara®

ADVD

My Advance Care Plan—Virginia

Communicating my healthcare wishes

Name _____ Social security number XXX - XX - _____

Address _____ City _____ State _____ Zip _____

Phone: (_____) _____ Date of birth _____ - _____ - _____

(Cross out any section(s) you do not wish to include in your document.)

Section 1: Healthcare agent

If I am unable to make decisions for myself, or unable to communicate my healthcare wishes about treatment, I appoint the person(s) listed below to be my designated healthcare agent(s), who will make my wishes known to my healthcare providers. I direct my healthcare providers and family to respect and honor my wishes.

Primary healthcare agent

Name _____ Phone: (_____) _____

Address _____ City _____ State _____ Zip _____

Secondary healthcare agent

Name _____ Phone: (_____) _____

Address _____ City _____ State _____ Zip _____

Additional healthcare agents can be named on an attached piece of paper and listed in decision-making order. My healthcare agent(s) shall make healthcare decisions based on my previously expressed wishes, my personal beliefs and values and shall be granted the power to make healthcare decisions as outlined in the Virginia Healthcare Decisions Act, 54.1-2984.

_____ If I initial this line, my agent WILL have the authority to restrict visitors in a healthcare facility.
(Initials)

Section 2: Living will

The below information will guide the decisions of your healthcare agent and providers if you can no longer make decisions for yourself. You may choose to complete all, some, or none of this section.

Values statements

"What is important to you?" Answer these statements by circling a number, 1 thru 5, where 1 is not important and 5 is very important to you.*

	Not important — Very important				
To live as long as possible (no matter the quality of life)	1	2	3	4	5
To die naturally, without the use of life-sustaining medical treatments (CPR, breathing machine, dialysis, feeding tube, etc.)	1	2	3	4	5
To be independent (able to care for myself, feed/bathe)	1	2	3	4	5
To be alert with family/friends (even if it means my pain is less controlled)	1	2	3	4	5
To receive care focused on relieving pain and controlling symptoms (even if it means I am less alert with family/friends)	1	2	3	4	5
To receive end of life care at home	1	2	3	4	5
To follow specific spiritual beliefs and cultural traditions (please explain below)	1	2	3	4	5

Other items you feel are important: _____

*Adapted from the Values Worksheet published by Group Health Cooperative, Seattle WA

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End of life

Consider the following question: If medical treatment is highly unlikely to change or improve your condition, would you want to receive life-sustaining treatments, OR would you want to allow a natural death?

Examples of life-sustaining treatments are Cardiopulmonary Resuscitation (CPR), breathing machine, kidney dialysis, feeding tube, etc.

Note: Providers are not required to follow or recommend medical treatment preferences that are medically or ethically inappropriate.

Place your initials in only one box for each statement. Note: The following examples are situations where medical treatment is highly unlikely to change or improve your condition.	**I do not want life-sustaining treatments; stop them if started; allow me to die naturally.**	**I am unsure. It would depend on the circumstances.** **Discuss with my healthcare agent.**	**I do want life-sustaining treatments.**
If I am unable to wake up (unconscious/in a coma), and my healthcare providers determine that medical treatments will not help, then:	(Initials)	(Initials)	(Initials)
If I am not aware of myself or others, unable to care for myself (severe brain damage/dementia), and my providers determine that medical treatments will not help, then:	(Initials)	(Initials)	(Initials)
If I am close to dying, and my providers determine that medical treatment would only delay the moment of my death, then:	(Initials)	(Initials)	(Initials)

Other statements and preferences (additional sheets can be attached):

_____

_____

Additional information

If you have attached additional pages, please initial beside any of the following as applicable:

_____ (Initials) Patient Protest (must be signed by physician) (see pg. 13 of ACP booklet or sentara.com/AdvanceDirectives)

_____ (Initials) Life-Sustaining Treatment During Pregnancy (see pg. 15 of ACP booklet or sentara.com/AdvanceDirectives)

_____ (Initials) Other attached pages

Section 3: Anatomical gift (whole body) or organ donation

_____ (Initials) I wish to be an organ donor OR _____ (Initials) I wish to be an anatomical gift (whole body) donor

For more information and to complete the registration to be an Organ Donor or Anatomical Gift (whole body) Donor, please visit your local/state organ or anatomical donation programs.

Section 4: Signatures (required)

By signing below, I indicate that I understand this document, and I am willingly and voluntarily executing it. I also understand that I may revoke all or any part of it at any time as provided by law.

My signature _____ **Date** _____

Witness #1 (print) _____ **Signature** _____

Witness #2 (print) _____ **Signature** _____

Patient label