My Advance Care Plan

Have the TALK – leave no doubt with your family about your healthcare wishes!

- ✓ Use the attached form to document your healthcare wishes.
- ✓ Remember that the most important part of making medical choices is to TALK about them!
- ✓ TALK about your Advance Care Plan with your family and your Healthcare Agents.
- ✓ TALK about it with your doctor.

If you have questions about making medical choices or completing your Advance Care Plan, call the Sentara Center for Healthcare Ethics at (757) 252-9550 for assistance.

Atención: si habla español, tiene a su disposición servicios lingüísticos gratuitos. Llame al 844-809-6648.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 844-809-6648 번으로 전화해 주십시오.

注意：如果您讲中文普通话，则将为您提供免费的语言辅助服务。请致电 844-809-6648。

ATTENTION: Language assistance services are available to you free of charge. Call 844-809-6648.

Sentara complies with applicable Federal Civil Rights Laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

THE U.S. LIVING WILL REGISTRY

This service is provided by Sentara FREE of charge to our community. You can store your Advance Care Plan on the Registry so it will be available to any health care provider in Virginia and North Carolina as well as any providers across the U.S. Once registered, you will receive an acknowledgment along with a wallet card and stickers for your ID cards that will alert medical professionals that you have an Advance Care Plan on file with the Registry and the 800 number so they can retrieve it.

If you want to have your document registered, you must complete the U.S. Living Will Registry Registration Agreement, giving the Registry permission to store your Advance Care Plan and provide it to any healthcare facility that requests a copy, and attach your Advance Care Plan.

What do I do with my ACP?

1. Make enough copies* and provide one each to:
    a. Your appointed Healthcare Agents
    b. Family members
    c. Doctor
    d. The US Living Will Registry through the Sentara Center for Healthcare Ethics***
2. Keep the original yourself in a safe and accessible place.
3. ***Mail a copy of your document to:

The Sentara Center for Healthcare Ethics
4705 Columbus Street, Suite 303
Virginia Beach VA 23462
or fax to our secure line at 757-995-7337

*Copies are the same as the original in Virginia

U.S. Living Will Registry® Registration Agreement

SOURCE CODE: 36901001

Registrant's Identifying Information (Please print clearly)

Name: First _____ Middle _____ Last _____ Suffix _____

Social Security# XXX - XX - _____ **Date of Birth** Month ____ Day ____ Year _____ (4 digits)

Email address for Registrant or Emergency Contact: _____

* Annual update reminders will be sent via email (email addresses will not be shared or sold)

Street Address _____ Apt # _____

City: _____ **State:** _____ **Zip Code:** _____

Primary Phone: (**)** _____ - _____ **Alternate Phone:** (_____) _____ - _____

Emergency Contact Name: _____ **Relationship:** _____

Address: _____

Primary Phone: (_____) _____ - _____ **Alternate Phone:** (_____) _____ - _____

I, _____ ("Registrant" or "I"), authorize U.S. Living Will Registry®, with offices at 808 South Ave. West, P.O. Box 2789 Westfield, NJ 07091-2789 ("Registry"), to electronically store a copy of my advance directive(s) provided to Registry with this registration form or subsequently, including but not limited to a living will, health care proxy, durable power of attorney for health care and/or financial matters, Medical or Physician Orders for Scope of Treatment (POST) organ donation wishes and emergency contact information ("Advance Directives"). I further authorize the Registry to make available a copy of the stored Advance Directive(s) to any health care provider or other person believed charged with giving effect to my Advance Directive(s) or assisting in same, who requests it in conjunction with my care, provided such a request is consistent with the Registry's policies and procedures, or as deemed advisable by the Registry in an emergency situation, or as required by law. The Advance Directive(s) that I am providing is my current, effective Advance Directive(s), and was signed and witnessed in accordance with the law of the state of my residence.

I hereby authorize Registry to make available a copy of my Advance Directive(s) to hospitals, physicians, or other health care providers involved with my care, or anyone who has access to the wallet identification ("ID") card provided to me by Registry. I understand this authorization is voluntary. I agree to notify Registry immediately if I decide to revoke or change my Advance Directive(s) stored with Registry and to provide Registry with a copy of any additional Advance Directive(s) that I sign. I understand that unless I terminate this authorization or inform Registry of revocation or changes to my Advance Directive(s), the Advance Directive(s) stored with Registry will be provided to health care providers in accord with Registry policies and practices.

I understand that Registry makes no representations about the validity of my Advance Directive(s) under federal or state law and that Registry bears no responsibility for the actions taken by health care providers in relation to my Advance Directive(s). I hereby waive any and all legal claims against Registry for the actions and omissions by any health care providers who receive a copy of my Advance Directive(s) from Registry and for any damages arising from the transmission or disclosure of the Advance Directive(s) I provide to Registry. Registry shall not be liable for the loss, destruction or unavailability of all or part of my Advance Directive(s).

I understand that I may revoke this authorization at any time by giving written notice of my revocation to Registry. This Agreement will remain in force until revoked by me or until terminated in accordance with the agreement between me and Registry or until registration is cancelled pursuant to the Registry's policies and procedures. When the Agreement is terminated, I understand that Registry will remove my Advance Directive(s) from its files.

I understand that anyone who gains access to my wallet ID card provided by Registry can use it to gain access to my Advance Directive(s) and personal information stored with Registry, and I will not hold the Registry liable for such authorized or unauthorized access.

I hereby agree to the terms set forth here in.

X _____ DATED: / /

Signature of Registrant

My Advance Care Plan **Virginia**

ADVD

COMMUNICATING MY HEALTHCARE WISHES

Name: _____ **Social Security Number:** **XXX** – **XX** - _____

Address: _____ **City:**_____**State & ZIP:** _____

Phone: (_____)_____ - _____ **Date of Birth:**_____-_____-_____

Sentara Healthcare Advance Directive
USLWR Source Code 36901001

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

Section I

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: _____ Address: _____

City:_____State & ZIP: _____ Cell Phone: (_____)_____- _____

Work Phone: (1____)_____- _____ Home Phone: (_____)_____- _____

Secondary Healthcare Agent:

Name: _____ Address: _____

City:_____State & ZIP: _____ Cell Phone: (_____)_____- _____

Work Phone: (_____)_____- _____ Home Phone: (_____)_____- _____

Additional Healthcare agents can be designated on an attached piece of paper; all Agents should be 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 II - Anatomical Gift (whole body) or Organ Donation:

_____ I wish to be an Organ Donor **OR** _____Anatomical Donor (whole body)
(Initials) (Initials)

If I am not already registered as an anatomical donor, I appoint the following person to make these arrangements on my behalf:

Name:_____ Phone: (_____)_____- _____

Address: _____ City: _____ State & ZIP: _____

Section III - Specific Healthcare Instructions:

In this section, you can indicate your preferences for life-sustaining treatments in certain situations. (Examples of life-sustaining treatments are CPR (cardiopulmonary resuscitation), a breathing machine, kidney dialysis, and a feeding tube). You may choose to complete all, some, or none of this section as you deem appropriate.

Choose only one box for each statement:	**No** life sustaining treatments; allow me to die naturally.	**I'm not sure;** it would depend on the circumstances. Discuss with my healthcare agent.	**Yes,** I would want life-sustaining treatments as long as appropriate
If I am unconscious, in a coma, or in a vegetative state and there is little or no chance of recovery…	(Initials)	(Initials)	(Initials)
If I have permanent, severe brain damage that makes me unable to recognize my family or friends (i.e. severe dementia, damage from stroke)…	(Initials)	(Initials)	(Initials)
If I have a permanent condition where others must help me with my daily needs (such as eating and toileting)…	(Initials)	(Initials)	(Initials)
If I have to be in bed and use a breathing machine 24/7 for the rest of my life…	(Initials)	(Initials)	(Initials)
If I have severe pain or other severe symptoms that cause suffering and can't be relieved…	(Initials)	(Initials)	(Initials)
If I have a condition that will result in death soon, even with life-sustaining treatments…	(Initials)	(Initials)	(Initials)

NOTE: Regardless of your choices above, you will still receive treatment to relieve pain and make you comfortable.

Additional Instructions/Preferences

_____

_____

_____

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

_____ (Initials) Patient Protest (must be signed by physician) (can be found at www.sentara.com/advancedirectives)

_____ (Initials) Life-Sustaining Treatment During Pregnancy (can be found at www.sentara.com/advancedirectives)

_____ (Initials) Other attached pages

Section IV

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 (required) **Date**

TWO WITNESS SIGNATURES REQUIRED

Print Name: _____ **Signature:** _____

Print Name: _____ **Signature:** _____