Advance Health Care Directive

VIRGINIA

LIFE CARE **planning**

my values, my choices, my care

kp.org/lifecareplan

KAISER PERMANENTE®

Full name: _____
Medical record number: _____

Introduction

This advance health care directive lets you share your values, your choices, and your instructions about your future health care. This form may be used to:

- Name someone you trust to make health care choices for you (your health care agent), OR
- Provide written instructions about your future health care, OR
- Both name a health care agent AND give written instructions for future health care.

Part 1 names a health care agent.

Part 2 gives you a chance to share what is of great value to you.

Part 3 gives written instructions about your future health care.

Part 4 lets you guide your agent's decision-making by stating your hopes and wishes.

Part 5 makes your advance health care directive legally valid in the state of Virginia.

Part 6 prepares you to share your wishes and this record with others.

Individuals with a terminal condition can perform an oral advance directive in the presence of an attending physician and two witnesses.

This advance health care directive will replace any advance health care directive you have filled out in the past. In the future, if you want to cancel or change your named agent, you must sign and date a written cancellation, physically cancel or destroy your record, or direct someone to do so in your presence, or orally express your wishes to cancel the document. Your cancellation becomes effective when you tell your attending physician.

Full name: _____

Medical record number: _____ Date of birth: _____

Mailing address: _____

Home phone: _____ Cell phone: _____

Work phone: _____ Email: _____

Full name: _____
Medical record number: _____

Part 1. My Health Care Agent

Choosing a health care agent: Choose someone who knows you well, whom you trust to honor your views and values, and who is able to make hard choices in stressful situations. Once you have picked your health care agent, take the time to talk about your views and care goals with that person.

If I am not able to communicate my wishes and health care decisions and my doctor and one other skilled doctor or clinical psychologist declare in writing that I am not able to make an informed decision regarding health care, I choose the following person(s) to honor my wishes and make my health care decisions.

My health care agent must make health care choices that are the same as my instructions in this document and my known desires. If my agent does not know my wishes, my agent must make health care decisions that he or she believes to be in my best interest, considering what he or she knows about my personal values.*

This form does not give my health care agent the power to make financial or other business decisions.

My main health care agent is:

Full name: _____ Relationship to me: _____

Home phone: _____ Cell phone: _____

Work phone: _____ Email: _____

Mailing address: _____

If I cancel my main health care agent's power or if my main agent is not willing, able, or reasonably available to make a health care decision for me, I name the people below as my first and second alternate agents.

First alternate health care agent:

Full name: _____ Relationship to me: _____

Home phone: _____ Cell phone: _____

Work phone: _____ Email: _____

Mailing address: _____

Second alternate health care agent:

Full name: _____ Relationship to me: _____

Home phone: _____ Cell phone: _____

Work phone: _____ Email: _____

Mailing address: _____

* The preceding authorization to make health care decisions does not involve the following absent a court order:

1. Nontherapeutic sterilization
2. Surgery only for psychosurgery
3. Abortion

Full name: _____

Medical record number: _____

Powers of my health care agent:

Unless I state otherwise, my health care agent has the following power when I am not able to speak for myself or make my own decisions:

A. Make choices for me about my health care. This includes choices about tests, medicine, and surgery. It also involves decisions to provide, not provide, or stop all forms of health care to keep me alive, including tube feedings and IV fluids.

B. Review and release my health records as needed to make decisions.

C. Decide which doctor, health providers, and organizations provide my health care.

D. Arrange for and make decisions about whole body, organ, tissue, and/or eye donation for research and education.

Additional powers of my health care agent:

Check the box below if you want your agent to have the following power:

❑ I want my agent to remain as my health care agent even if a dissolution, annulment, or termination of our marriage or domestic union has been completed.

Please provide any additional comments or restrictions to the previous section. (For example, you may name people you would or would not want to be involved in decisions on your behalf. You may also specify decisions you would not want your agent to make.) Attach additional pages if necessary.

Full name: _____

Medical record number: _____

Part 2. My Values

I want my agent and loved ones to know what matters most to me, so that they can make choices about my health care that match who I am and what is of great value to me.

To give you a sense of what matters most to me, I'd like to tell you some things about myself, such as how I enjoy spending my time, whom I like to be with, and what I like to do. I'd also like to tell you about the circumstances that would make life no longer worthwhile for me.

1. If I were having a really good day, I would be doing the following:

2. What matters most to me is:

3. Life would no longer be worth living if I were not able to:

Full name: _____

Medical record number: _____

Part 3. My Health Care Instructions: My Choices, My Care

In the situation below, we ask you to consider a sudden unexpected event. You will always speak for yourself if you are able; in this situation, you are not able to speak for yourself.

If I become not able to communicate or make my own choices, I ask that my health care agent represent my choices as listed below and that my doctors and health care team honor them. If my health care agent or alternate agents are not available or are not able to make decisions on my behalf, this document acts as my wishes.

Note: If you choose not to give written instructions, your health care agent will make decisions based on your spoken wishes. If your wishes are unknown, your agent will make decisions based on what he or she believes is in your best interest, considering your values.

1. Care to prolong life

Keep in mind these situations:

You have a sudden accident or stroke.

Doctors have diagnosed you with a brain injury, leaving you not able to recognize yourself or your loved ones. The doctors have told your agent and/or family that you are not expected to regain these abilities. Life-sustaining treatments, such as a ventilator (i.e., breathing machine) or a feeding tube are needed to keep you alive. In this situation, what would you want?

I would want to be kept comfortable and:

choose one

- ❑ I would want to STOP life-sustaining treatment. I realize this would likely lead me to die sooner than if I were to continue treatment.
- ❑ I would want life-sustaining treatments to continue as long as possible.

Please give any additional instructions about life-sustaining treatments. For example, you may want to state a set time period that you would want to be kept alive if there were no change to your health.

Full name: _____
Medical record number: _____

2. CPR (Cardiopulmonary Resuscitation)

CPR is an attempt to bring you back to life when your heart and breathing have stopped. It may involve chest compressions (forceful pushing on the chest to make the heart contract), medicines, electrical shocks, and a breathing tube.

You have a choice about CPR. CPR can save lives. It is not as effective as most people think. CPR works best if done quickly, within a few minutes, on a healthy adult. When CPR is performed, it can result in broken ribs, punctured lungs, or brain damage from lack of oxygen.* If you would like more information about CPR, please request the brochure called **CPR: My Choice.**

If your heart and breathing stop, what would you want?

choose one

- ❑ I always want CPR attempted.
- ❑ I never want CPR attempted, but rather, want to permit a natural death.†
- ❑ I want CPR attempted unless the doctor treating me determines any of the following:
  - I have an incurable illness or injury and am dying, OR
  - I have no reasonable chance of survival if my heart or breathing stops, OR
  - I have little chance of survival if my heart or breathing stops and the process of resuscitation would cause major pain.

* Research shows that if you are in a hospital and get CPR, you have a 22% chance of it working and you leaving the hospital alive.

Ehlenbach, W., Barnato, A. E., Curtis, J. R., et al (2009). Epidemiologic study of in-hospital cardiopulmonary resuscitation in the elderly. *New England Journal of Medicine*, 361:22-31. Girotra, S., Brahmajee K., Nallamothu, M.D., et al (2012). Trends in survival after cardiac arrest. *New England Journal of Medicine*, 167:1912-20.

† If you are certain you do not want CPR, please discuss other documents you may want to fill out with your doctor.

Full name: _____
Medical record number: _____

Part 4. My Hopes and Wishes (Optional)

1. My thoughts and feelings about where I would prefer to die:

2. I want my loved ones to know that if I am nearing my death, I would appreciate the following for comfort and support (prayers, rituals, music, etc.):

3. Religious or spiritual affiliation:

I am of the _____ faith, and am a member of (faith/spiritual group) _____ _____ in (city) _____, (phone number) _____. I would like my agent to tell them if I am seriously ill or dying. I would like to include in my funeral, if possible, the following (people, music, rituals, etc.):

4. Other wishes/instructions:

Organ donation

If you are interested in donating organs when you die, you can declare your donor status when getting or renewing a driver's license or by registering through the donor registry found at **http://www.donatelifevirginia.org/**.

Full name: _____
Medical record number: _____

Part 5. Making This Document Legally Valid

To make your advance health care directive legally valid in Virginia, it must be signed by two adult witnesses.

Two Witnesses

1. Any person over the age of 18, a spouse, other family member, or health care provider.
2. When you are with your witnesses, sign or acknowledge your signature.
3. You will sign below.
4. Witnesses will sign on page 9.

MY SIGNATURE

Print Full Name: _____

Signature: _____ Date: _____

Full name: _____
Medical record number: _____

STATEMENT OF WITNESSES:

I declare under penalty of perjury under the laws of Virginia:

1. That the person who signed or approved this advance health care directive is personally known to me or that the individual's identity was proven to me by convincing proof,
2. That the person signed or approved this advance health care directive in my presence, and
3. That the person appears to be of sound mind and under no force, fraud, or undue influence.

Witness Number One:

Print full name: _____

Address: _____

Signature: _____ Date: _____

Witness Number Two:

Print full name: _____

Address: _____

Signature: _____ Date: _____

Full name: _____
Medical record number: _____

Part 6. Next Steps

Now that you have filled out your advance health care directive, you should also take the following steps.

Discuss:

1. Review your health care wishes with the person you have asked to be your agent (if you haven't already done so). Make sure he or she feels able to do this important job for you in the future.
2. Talk to the rest of your family and close friends who might be involved if you have a serious illness or injury. Make sure they know who your health care agent is and what your wishes are.

Give copies:

1. Give your health care agent a copy of your advance health care directive.
2. Give a copy of your advance health care directive to your doctor or your local Kaiser Permanente Medical Records Department.
3. Make a copy for yourself and keep it where it can be easily found.

Take with you:

1. If you go to a hospital or nursing home, take a copy of your advance health care directive and ask that it be placed in your health record.
2. Take a copy with you any time you will be away from home for an extended period of time.

Review often:

1. Review your health care wishes whenever any of the "Five D's" occur:

   Decade – when you start each new decade of your life

   Death – when you experience the death of a loved one

   Divorce – when you go through a divorce or other major family change

   Diagnosis – when you are diagnosed with a serious health condition

   Decline – when you feel a major decline or deterioration of an existing health condition, especially when you are not able to live on your own

Changing your advance health care directive:

If your wishes change, fill out a new advance health care directive, tell your agent and your family, and give a copy to Kaiser Permanente.

Copies of this document have been given to:

- Primary (main) health care agent — Full name: _____ Telephone: _____
- Alternate health care agent #1 — Full name: _____ Telephone: _____
- Alternate health care agent #2 — Full name: _____ Telephone: _____
- Health care provider/clinic — Name: _____ Telephone: _____
- Others: — Name: _____ Telephone: _____

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