My Advance Care Plan

Virginia

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: (_____)_______- _________ 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

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

______ 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
(Initials)

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:** ______________________