Part C lets you give your agent the power to consent to treatment that you say "no" to. This power applies only if you cannot make informed decisions. If you do not want to give your agent this power, you can skip or cross through Part C.

This power has two parts:
1. You can give your agent the power to consent over your objection to inpatient mental health admission
and/or
2. You can give your agent the power to consent over your objection to other health care

You can also exclude specific treatments that you always want to be able to object to.

IMPORTANT: You need to have one of the professionals listed in the box sign this page to make Part C legally binding. Before signing, the professional will check to see if you understand the consequences of giving your agent the powers described on this page.

If you are not completing Part C, you do not need to have this page signed.

You may use **Section 2** to give directions about your health care. You may skip over or cross out any parts that you do not want to fill out. You can use these parts even if you do not pick an agent.

Part A lets you provide background information to your health care providers. It includes no instructions.

C. What My Agent Can Do Over My Objection

When I am not able to make informed decisions about my health care, I may say "no" to treatment that I actually need. If my agent and my physician believe that treatment is medically appropriate, my agent has the power:

☐ _____ 1. To consent to my admission to a mental health care facility as permitted by law, even if I object.

and/or

☐ _____ 2. To consent to other health care that is permitted by law, even if I object.

This authority includes all health care except for what I have written in the next sentence or elsewhere in this document. My agent does **not** have the authority to consent to _____

_____ over my objection.

I am a licensed: ☐physician, ☐clinical psychologist, ☐physician assistant, ☐nurse practitioner, ☐professional counselor, ☐clinical social worker. I am familiar with the person who has made this advance directive for health care. I attest that this person is presently capable of making an informed decision and that this person understands the consequences of the special powers given to his/her agent by this Subsection C of this advance directive.

Signature Date

Printed Name and Address

Section 2: My Health Care Preferences and Instructions

My preferences and instructions for my health care are written in this section. My health care agent and any health care providers working with me are directed to provide care in line with my stated instructions and preferences. *I understand that my providers do not have to follow preferences or instructions that are medically or ethically inappropriate or against the law.*

A. My Health Conditions and Current Treatments

1. My current health condition(s) and important things about my condition(s) that health care providers should know:

You can also provide medication information by attaching a list of your medications to this AD. Or you can write where/how people can get your medication information in box A.4 (e.g., calling your primary care doctor).

2. Symptom(s) that indicate I need prompt medical attention:

3. My medications and dosages as of _____/_____/20____:

Medication	Dose	How/when I take it
☐ See back of this page for more		☐ See attached list for more

4. Other important information regarding medications (allergies, side effects):

The information in your AD may be shared by your health care provider with other health care providers so that treatment can be given in line with your AD. You can help your different providers get in contact with each other by providing their phone numbers here.

B. Information Sharing

My current providers, who have information to help with my care, are:

Name	Provider type (e.g., PCP)	Phone number

C. Emergency Contacts

I authorize the health care providers and other people helping me to contact my health care agent. This authorization includes if I am admitted to a mental health facility.
I also authorize them to contact the following people to share information about my location, condition and needs:

Name:_____ Relationship to me: _____

Ph. No. (home): _____ (cell):_____

Ph. No. (work): _____ Email: _____

Home Address:_____

Limit of details to share, if any: _____

Name:_____ Relationship to me: _____

Ph. No. (home): _____ (cell):_____

Ph. No. (work): _____ Email: _____

Home Address:_____

Limit of details to share, if any: _____

Part D lets you give your preferences for medications. You may refer to specific medications or types of medications.

Your physician must consider your preferences. But medication decisions must be based on your physician's clinical judgment too.

Your physician is not required to follow preferences that are medically or ethically inappropriate.

You have the option of telling providers more information about your choices—it can help them to better follow your wishes.

In general, your agent cannot authorize and your physician cannot order use of the medications that you refuse here. There are some narrow exceptions permitted by law, such as emergencies.

You may leave the option open for your agent to consent to a refused medication if circumstances indicate the medication really is the most appropriate one under the circumstances.

You have the option of telling providers more information about your choices—it can help them to better follow your instructions.

You can add any other preferences about medication here, such as whether you prefer shots, pills, or liquid forms of medicines.

You may use **E.1** to provide any other information that is important to your care. If you need more space, you may attach additional documents. If you use attachments, you should be sure to describe them clearly here.

D. Medication

1. Medication Preferences

I prefer that the following medications (or classes or types of medication) be tried first in a crisis or emergency:

Medication name or class	As treatment for…

I prefer these medications because:

2. Medication Authorization and Refusal Instructions

General authorization to consent to medications: Generally, I authorize my agent to consent to medications that my treating physician says are appropriate.

Medication refusal instructions: Although I generally authorize my agent to consent to medications, I specifically do **not** consent to the medications listed below. (This includes brand-name, trade-name, or generic equivalents.)

Although I do not consent to these medications, I realize that my condition and needs may change. So, I also state whether my agent can consent to the medication if necessary. My agent should consent only if my physician finds that the medication is clearly the most appropriate treatment for me under the circumstances.

Medication name or class that I do not want	As treatment for…	My agent can authorize it if necessary

I do not want these medications because:

3. Additional preferences about medications:

E. Other Health Care Details

1. In General

If you gave your agent the power to make visitation decisions, your agent must make visitation decisions based on any instructions you write here.

Part F lets you give details about what treatment you would want if you cannot recover from a severe illness or injury.

The first type of condition that you can give treatment instructions for is in case your death is expected very soon. For example, if you were in the last stage of cancer.

For F.1, check only 1 box and initial the line.

If the pre-made options above do not fit what you want, you may write your own preferences and instructions.

The second type of condition that you can give treatment instructions for is in case your brain becomes severely and permanently damaged. For example, if you were in a permanent coma.

Sometimes people in a permanent coma can be kept alive for a long time, even though they are not expected to recover. If this were to happen, you may limit how long treatments may be tried before they are stopped if your condition does not improve.

For F.2, check only 1 box and initial the line.

If the pre-made options do not fit what you want, you may write your own preferences and instructions.

2. Visitation Instructions

If I am in a health care facility, this is how I want visitation to be handled:

F. Life-Prolonging Treatment

1. If my doctor determines that my death is imminent (very close) and medical treatment will not help me recover, then:

☐ ____ I do not want any treatments to prolong my life. This includes tube feeding, IV fluids, cardiopulmonary resuscitation (CPR), ventilator/respirator (breathing machine), kidney dialysis or antibiotics. I understand that I still will receive treatment to relieve pain and make me comfortable.

☐ ____ I want all treatments to prolong my life as long as possible within the limits of generally accepted health care standards. I understand that I will receive treatment to relieve pain and make me comfortable.

☐ ____ Other choices, as follows:

2. If my condition makes me unaware of myself or my surroundings or unable to interact with others, and it is reasonably certain that I will never recover this awareness or ability even with medical treatment, then:

☐ ____ I do not want any treatments to prolong my life. This includes tube feeding, IV fluids, cardiopulmonary resuscitation (CPR), ventilator/respirator (breathing machine), kidney dialysis or antibiotics. I understand that I still will receive treatment to relieve pain and make me comfortable.

☐ ____ I want all treatments to prolong my life as long as possible within the limits of generally accepted health care standards. I understand that I will receive treatment to relieve pain and make me comfortable.

☐ ____ I want to try treatments for a period of time in the hope of some improvement of my condition. I suggest _____ as the period of time after which such treatment should be stopped if my condition has not improved. Any agent or surrogate may specify the exact time period in consultation with my physician. I understand that I still will receive treatment to relieve pain and make me comfortable.

☐ ____ Other choices, as follows:

If you leave this section blank, your agent will have the authority to donate your organs, eyes and tissues or your whole body. If you do not want your agent to have that authority, write in the box "I do not want to be an organ donor."

If you want to be an organ donor, check only 1 box and initial the line.

If you want to be an organ donor, you may also use this space to write any specific instructions you wish to give about organ donation.

You can also register or change your directions on the donor registry, www.DonateLifeVirginia.org.

Two adult witnesses are needed to make your advance directive valid. Any person over the age of 18 may be a witness. This includes a spouse or relative, as well as employees of health care facilities and physician's offices who act in good faith.

This form meets the requirements of Virginia's Health Care Decisions Act. If you have legal questions about this form or would like to develop a different form to meet your particular needs, you should talk with an attorney.

Note: If you have added pages with instructions, those pages should be signed and witnessed, too.

This advance directive should be accepted in other states based on "reciprocity" laws that honor valid out of state documents. Check with your health care provider.

Section 3: Organ Donation

☐ ____ I donate my organs, eyes and tissues for use in transplantation, therapy, research and education. I direct that all necessary measures be taken to ensure the medical suitability of my organs, eyes or tissues for donation.

OR

☐ ____ I donate my whole body for research and education.

Section 4: Required Signatures

Right to Revoke: I understand that I may cancel all or part of my AD at any time that I am able to understand the consequences of doing so.

Affirmation: I am signing below to show that I understand this document and that I made it voluntarily.

Date _____ Signature _____

The above person signed this advance directive in my presence.

Witness Signature _____ Witness Printed _____

Witness Signature _____ Witness Printed _____

It is your responsibility to provide a copy of your advance directive to your health care providers. You also should provide copies to your agent, close relatives and/or friends.

In addition to sharing hard copies, you are encouraged to store your advance directive in Virginia's free Advance Directive Registry located at the Virginia Department of Health website: https://www.connectvirginia.org/adr/.

If you have stored your advance directive in the Registry, initial here: _____