RIVERSIDE
Advance Care Planning

Advance Directive

An Advance Directive is only part of your medical plan for the future. It will be more helpful to your family and friends if you spend some time thinking about your values and how they affect your medical decisions in addition to writing your Advance Directive. A full discussion guide is available by calling 757-856-7030 (toll-free 1-877-287-6061), or online at www.riversideonline.com

To complete your Advance Directive:

Step 1. Talk about it.

What experiences have you had with someone who died? Have experiences or news stories made you think about what you would want if anything suddenly happened to you?

Step 2. Choose Someone to Speak for You.

If you cannot speak for yourself, doctors need to know who you trust to speak for you. This person should understand choices that you would make and be willing to honor them even if they disagree.

Step 3. Decide what kind of medical treatment you would want if you were not expected to recover.

If you had a sudden illness or brain injury and were not expected to recover, your healthcare agent should know if you would want to be kept alive on life support. Your healthcare agent should also know how much treatment you would want at the end of a terminal illness.

Step 4. Write It Down.

When you have thought about these things and talked with the people who are close to you, you are ready to complete your advance directive. You can use an Advance Directive to tell people about the treatments you do want as well as anything that you do not want. You can change your Advance Directive any time, as long as you can make and understand your own decisions.

Step 5. Share it.

Give a copy of your Advance Directive to your Healthcare Agent, others who are close to you, and your doctor.

At Riverside, we are proud to honor your health care choices.

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ADVANCE MEDICAL DIRECTIVE

I, _____ (Patient Date of Birth _____) am capable of making an informed decision and make this Advance Directive as an expression of my wishes for medical treatment. This will only be used if I ever become incapable of making an informed decision.
If there are any sections of this form that you do not want to complete, cross through it and sign the center of the "X."

SECTION I - APPOINTMENT OF A HEALTHCARE AGENT

If you do not appoint a health care agent, your nearest relative, as defined by the Code of Virginia, will be relied upon to provide informed consent for providing, withholding or withdrawing medical treatments if you become incapable of making an informed decision.
I hereby appoint the person below to be my primary agent.

Name _____ Telephone _____

Address _____ Cell Phone _____

If my primary agent is not available or is unable or unwilling to act as my agent, then I appoint the person below to serve in that capacity:

Name _____ Telephone _____

Address _____ Cell Phone _____

Powers of My Healthcare Agent *(Cross through any language you do not want and add any language that you do want.)*

The powers of my agent shall include the following:

A. To consent to or refuse or withdraw consent to any type of health care including, but not limited to, artificial respiration, artificially administered nutrition and hydration, and cardiopulmonary resuscitation. This authorization specifically includes the power to consent to the administration of dosages of pain-relieving medication in excess of recommended dosages in an amount sufficient to relieve pain, even if such medication carries the risk of addiction or of inadvertently hastening my death
B. To request, receive, and review any information, regarding my physical or mental health, and to consent to the disclosure of this information
C. To employ and discharge my health care providers
D. To authorize my admission to or discharge from any medical care facility
E. To continue to serve as my agent even if I become incapable of making an informed decision and then protest their authority
F. To authorize my participation in health care research that might benefit me
G. To authorize my participation in health care research to promote human well-being, even if it would not benefit me
H. To restrict the following people from visiting me while I am in a health care facility:

_____

(If this section is left blank, I do not want restrictions on visitors.)

To give your agent the authority to override your protest to instructions provided in this document, complete the Protest Addendum, available at www.riversideonline.com or by calling (757) 856-7030; toll free (877) 287-6061.

SECTION II - GENERAL HEALTH CARE INSTRUCTIONS

I specifically direct that I receive the following health care if it is medically appropriate:

_____

_____

_____

I specifically direct that the following health care not be provided to me, even if I have not been diagnosed as terminally ill:

_____

_____

SECTION III - END OF LIFE HEALTH CARE INSTRUCTIONS

In sections A and B below, put your initials next to the statement that communicates your wishes. If you do not want to make specific instructions, but instead allow your healthcare agent to make choices that are consistent with your values, you may cross through this section and write "no instructions" in the margin.

A. Terminal condition: If my attending physician determines that my death is imminent (very close) and medical treatment will not help me recover: (choose one of the following by placing your initials in the blank beside the item)

____ I do not want any treatments to prolong my life. This includes tube feeding, IV fluids, cardiopulmonary resuscitation (CPR), ventilator/respirator (breathing machine), and kidney dialysis. I direct that I be allowed to die naturally. Medication or procedures that provide comfort or alleviate pain shall continue to be provided.

____ I want all medically appropriate treatments to prolong my life as long as possible.

Other instructions: _____

_____

B. Permanent and severe illness or brain injury: 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: (choose one of the following by placing your initials in the blank beside the item)

____ I do not want any treatments to prolong my life. This includes tube feeding, IV fluids, cardiopulmonary resuscitation (CPR), ventilator/respirator (breathing machine), and kidney dialysis. I direct that I be allowed to die naturally. Medication or procedures that provide comfort or alleviate pain shall continue to be provided.

____ I want all medically appropriate treatments to prolong my life as long as possible.

____ 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. My healthcare agent should decide on this time period together with my physician.

Other instructions: _____

_____

SECTION IV - ORGAN OR TISSUE DONATION

___ I donate my organs, eyes and tissues for use in transplantation

___ I donate my organs, eyes and tissues for use in therapy, research and education.

___ I do not wish to donate organs or tissues

Other instructions:_____

_____

Note: if you wish to donate your whole body to science, you must contact the Virginia Anatomical Board at (800)447-1706.

SECTION V - SIGNATURE AND RIGHT TO REVOKE

By signing below, I indicate that I am emotionally and mentally capable of making this advance directive and that I understand the purpose and effect of this document.
I understand that I may revoke all or any part of this document, as long as I am capable of understanding my actions, in the following ways:

- In writing, with my signature and date
- By telling someone that I intend to revoke it
- By destroying this advance directive or directing that someone destroy it in my presence

My Signature: _____ Date: _____

Patient Date of Birth: _____

Witnesses: this document was signed in my presence.

Witness #1 _____ Date: _____

Witness Name (print) _____

Witness #2 _____ Date: _____

Witness Name (print) _____

<u>Important Notes:</u> A Notary is not required. All three pages of this document should be kept together, even if you crossed out some sections.

Congratulations on taking this important step!

Talk with your family and people who are close to you about what you have written on your Advance Directive. Give copies to your Healthcare Agent and your doctors, and remember to review it often.