Inova™

3ADV

I, _____ _____ willingly and voluntarily
First Name Last Name Date of Birth

make known my wishes in the event my physician determines I am incapable of making an informed decision, as follows:

I. Appointment and Powers of my Agent

I hereby appoint: _____
Name of Primary Agent Telephone Number City/State

as my agent to make health care decisions on my behalf as authorized in this document. If the primary agent is not reasonably available or is unable or unwilling to act as my agent, then I appoint the following as back-up agent(s):

_____
Name of Back-up Agent(s) Telephone Number City/State

My agent shall have authority only when, and for as long as, I have been determined to be incapable of making an informed decision. I want my agent to follow my desires and preferences as stated in this document or as otherwise known to my agent when making health care decisions on my behalf. If my agent cannot determine what health care choice I would have made for myself, I want my agent to make a choice based upon what she/he believes is in my best interests. The powers of my agent shall include the following, except those that I have crossed out:

A. To consent, refuse, or withdraw consent to any type of health care, treatment, surgical or diagnostic procedure, medication, use of technology or other procedure that affects my bodily function, including, but not limited to, artificial respiration (breathing machine), artificially administered nutrition (tube feeding) and hydration (IV fluids), and cardiopulmonary resuscitation (CPR).
B. To request, receive, and review any written or verbal information regarding my physical or mental health, including but not limited to, medical and hospital records, and to consent to the disclosure of this information.
C. To employ and discharge my health care providers.
D. To take any lawful actions that may be necessary to carry out these decisions, including the granting of releases of liability to medical providers.
E. My agent has the authority to make decisions regarding funeral arrangements, unless I appoint an alternative person here: _____
Name Telephone Number City/State

II. Specific Instructions About My Health Care OR ☐ I am not completing this section

_____

_____

I understand this document and I am willingly and voluntarily signing it. I also understand that I may revoke all or any part of it at any time as provided by law**. I further understand that I may change my health care agent at any time by creating a new advance directive for healthcare and providing a copy to my healthcare provider.**

Patient (signature): _____ Date: _____

The person named above signed this advance directive in my presence (TWO adult witnesses needed):

Witness (signature):_____ (print name): _____ Date: _____

Witness (signature):_____ (print name): _____ Date: _____

_____By initialing here, I am choosing not to make any further decisions about my care. **If I wish to make further decisions about my care, I will complete and sign the reverse side of this page.**

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ❑ Male ❑ Female

Inova

Virginia Advance Directive for Health Care

☐ IAH ☐ IFH ☐ IFOH ☐ ILH ☐ IMVH

CAT # 30936 / R091923 • PKGS OF 50

III. Additional Health Care Instructions OR ☐ I am not completing this section

1. In the event my death is imminent (very close) and medical treatment will not help me recover:

   Choose ONE option:

   ☐ I do not want treatment to prolong my life. This may include 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. **(OR)**

   ☐ 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.

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:

   Choose ONE option:

   ☐ I do not want treatment to prolong my life. This may include 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. **(OR)**

   ☐ 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. **(OR)**

   ☐ 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. The exact time period is at the discretion of my agent or surrogate in consultation with my physician. I understand that I still will receive treatment to relieve pain and make me comfortable.

IV. Additional Mental Health Care Instructions OR ☐ I am not completing this section

You may use this section to give additional instructions about your mental health care. If you do not give specific instructions, your mental health care will be based on your values and wishes, if known, to the extent allowable by law.

A. I specifically request that I receive the following mental health care if it is medically appropriate:
_____

B. I specifically request that I not receive the following mental health care:
_____

C. My agent named on the front of this document may also make mental health decisions in the event I am unable to make them for myself. ☐ Yes ☐ No

I understand this document and that I am willingly and voluntarily signing it. I also understand that I may revoke all or any part of it at any time as provided by law. **I further understand that I may change my health care agent at any time by creating a new advance directive for healthcare and providing a copy to my healthcare provider.**

Patient (signature): _____ Date: _____

The person named signed this advance directive in my presence (TWO adult witnesses needed):

Witness (signature):_____ (print name): _____ Date: _____

Witness (signature):_____ (print name): _____ Date: _____

Interpreter Information (To be completed by Inova staff, if applicable)**:**
☐ In person ☐ Telephonic ☐ Video Interpreter name/ID number (if applicable) _____
☐ Patient/Designated Decision Maker was offered and refused interpreter ☐ Waiver signed

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ❑ Male ❑ Female

Inova

Virginia Advance Directive for Health Care

CAT # 30936 / R091923 • PKGS OF 50