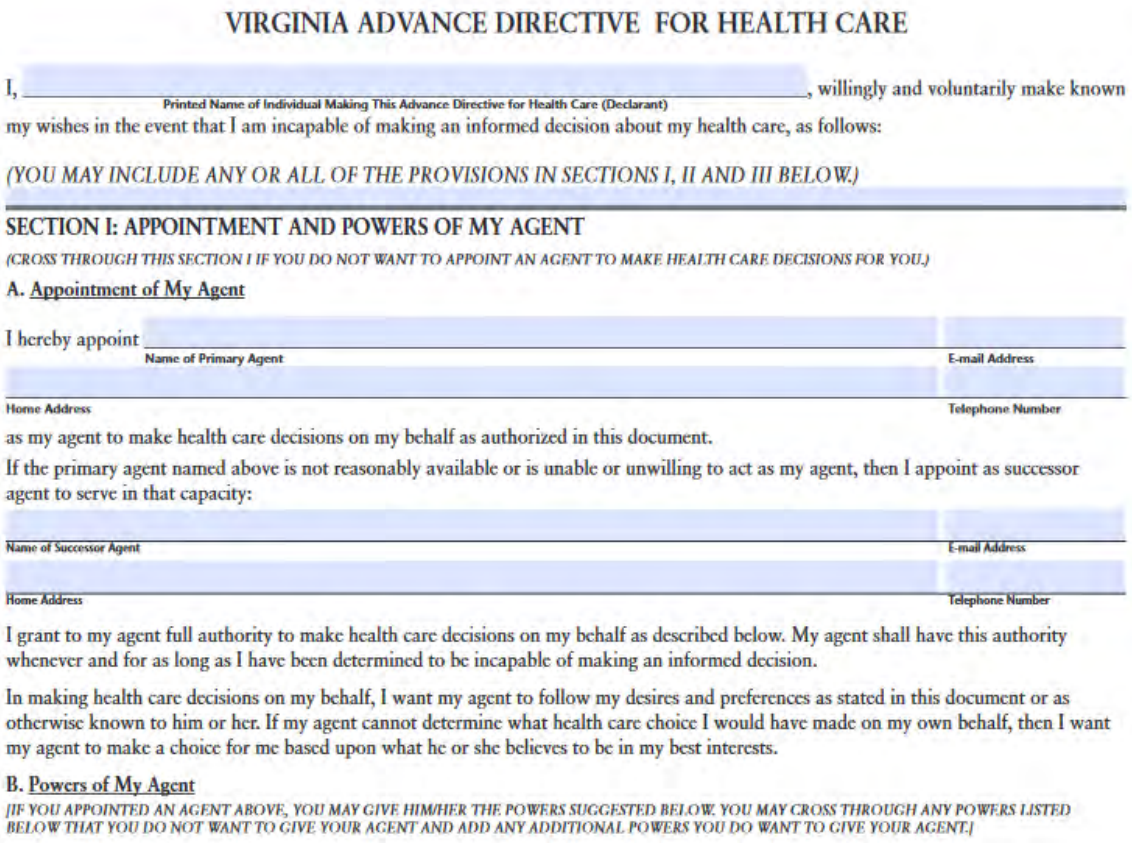
Advance Care Planning Document Types

Advance Directive

A legal document generally comprised of two parts: a medical power of attorney and a living will. The first part typically names a specific person to make medical decisions on behalf of the patient, usually only when the patient loses capacity to make decisions. The person named by the patient is referred to as an "agent" or "medical power of attorney (PoA)." The second part specifies the patient's wishes for medical care in certain situations, such as if the patient becomes terminally ill or permanently unconscious, and may include a mental health care section. There is no single standard form for advance directives, but they must meet certain requirements to be legally valid.



VIRGINIA ADVANCE DIRECTIVE FOR HEALTH CARE

I, _____, willingly and voluntarily make known
Printed Name of Individual Making This Advance Directive for Health Care (Declarant)
my wishes in the event that I am incapable of making an informed decision about my health care, as follows:

(YOU MAY INCLUDE ANY OR ALL OF THE PROVISIONS IN SECTIONS I, II AND III BELOW.)

SECTION I: APPOINTMENT AND POWERS OF MY AGENT

(CROSS THROUGH THIS SECTION I IF YOU DO NOT WANT TO APPOINT AN AGENT TO MAKE HEALTH CARE DECISIONS FOR YOU.)

A. Appointment of My Agent

I hereby appoint _____ _____
Name of Primary Agent E-mail Address

_____ _____
Home Address Telephone Number

as my agent to make health care decisions on my behalf as authorized in this document.

If the primary agent named above is not reasonably available or is unable or unwilling to act as my agent, then I appoint as successor agent to serve in that capacity:

_____ _____
Name of Successor Agent E-mail Address

_____ _____
Home Address Telephone Number

I grant to my agent full authority to make health care decisions on my behalf as described below. My agent shall have this authority whenever and for as long as I have been determined to be incapable of making an informed decision.

In making health care decisions on my behalf, I want my agent to follow my desires and preferences as stated in this document or as otherwise known to him or her. If my agent cannot determine what health care choice I would have made on my own behalf, then I want my agent to make a choice for me based upon what he or she believes to be in my best interests.

B. Powers of My Agent

[IF YOU APPOINTED AN AGENT ABOVE, YOU MAY GIVE HIM/HER THE POWERS SUGGESTED BELOW. YOU MAY CROSS THROUGH ANY POWERS LISTED BELOW THAT YOU DO NOT WANT TO GIVE YOUR AGENT AND ADD ANY ADDITIONAL POWERS YOU DO WANT TO GIVE YOUR AGENT.]

Living Will

An older form of an advance care planning document in which the patient expresses their choices about medical care in the event that they face a terminal illness or permanent unconsciousness and cannot speak for themselves. There is no standard form for living wills, and many advance directives have the 'living will' wishes inserted into the overall form.

DECLARATION

This declaration is made this _____ day of _____ (month, year).

I, _____ being of sound mind, willfully and voluntarily make known my desires that my moment of death shall not be artifically postponed.

If at any time I should have an incurable and irreversible injury, disease, or illness judged to be a terminal condition by my attending physician who has personally examined me and has determined that my death is imminent except for death delaying procedures, I direct that such procedures which would only prolong the dying process be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication, sustenance, or the performance of any medical procedure deemed necessary by my attending physician to provide me with comfort care.

In the absence of my ability to give directions regarding the use of such death delaying procedures, it is my intention that this declaration shall be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

Signed _____

Durable Do Not Resuscitate (DDNR) Order:

A signed physician's order that authorizes withholding cardiopulmonary resuscitation in the event that the patient goes into cardiac and/or respiratory arrest. DDNR orders are issued with the consent of the patient or an appropriate decision-maker, and health care providers in any facility or in the community may rely on them as a valid order. If the DDNR order is signed by the patient, only the patient may revoke it. DDNR orders are not advance directives per se, because they are medical orders, but they are created in advance to provide future guidance about medical care.

Durable Do Not Resuscitate Order

Virginia Department of Health

Patient's Full Legal Name _____ **Date** _____

Physician's Order

I, the undersigned, state that I have a bona fide physician/patient relationship with the patient named above. I have certified in the patient's medical record that he/she or a person authorized to consent on the patient's behalf has directed that life-prolonging procedures be withheld or withdrawn in the event of cardiac or respiratory arrest.

I further certify (must check 1 or 2):

☐ 1. The patient is CAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment. (Signature of patient is required)

☐ 2. The patient is INCAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment because he/she is unable to understand the nature, extent or probable consequences of the proposed medical decision, or to make a rational evaluation of the risks and benefits of alternatives to that decision.

If you checked 2 above, check A, B, or C below:

☐ A. While capable of making an informed decision, the patient has executed a written advanced directive which directs that life-prolonging procedures be withheld or withdrawn.

☐ B. While capable of making an informed decision, the patient has executed a written advanced directive which appoints a "Person Authorized to Consent on the Patient's Behalf" with authority to direct that life-prolonging procedures be withheld or withdrawn. (Signature of "Person Authorized to Consent on the Patient's Behalf is required.)

☐ C. The patient has not executed a written advanced directive (living will or durable power of attorney for healthcare). (Signature of "Person Authorized to Consent on the Patient's Behalf is required)

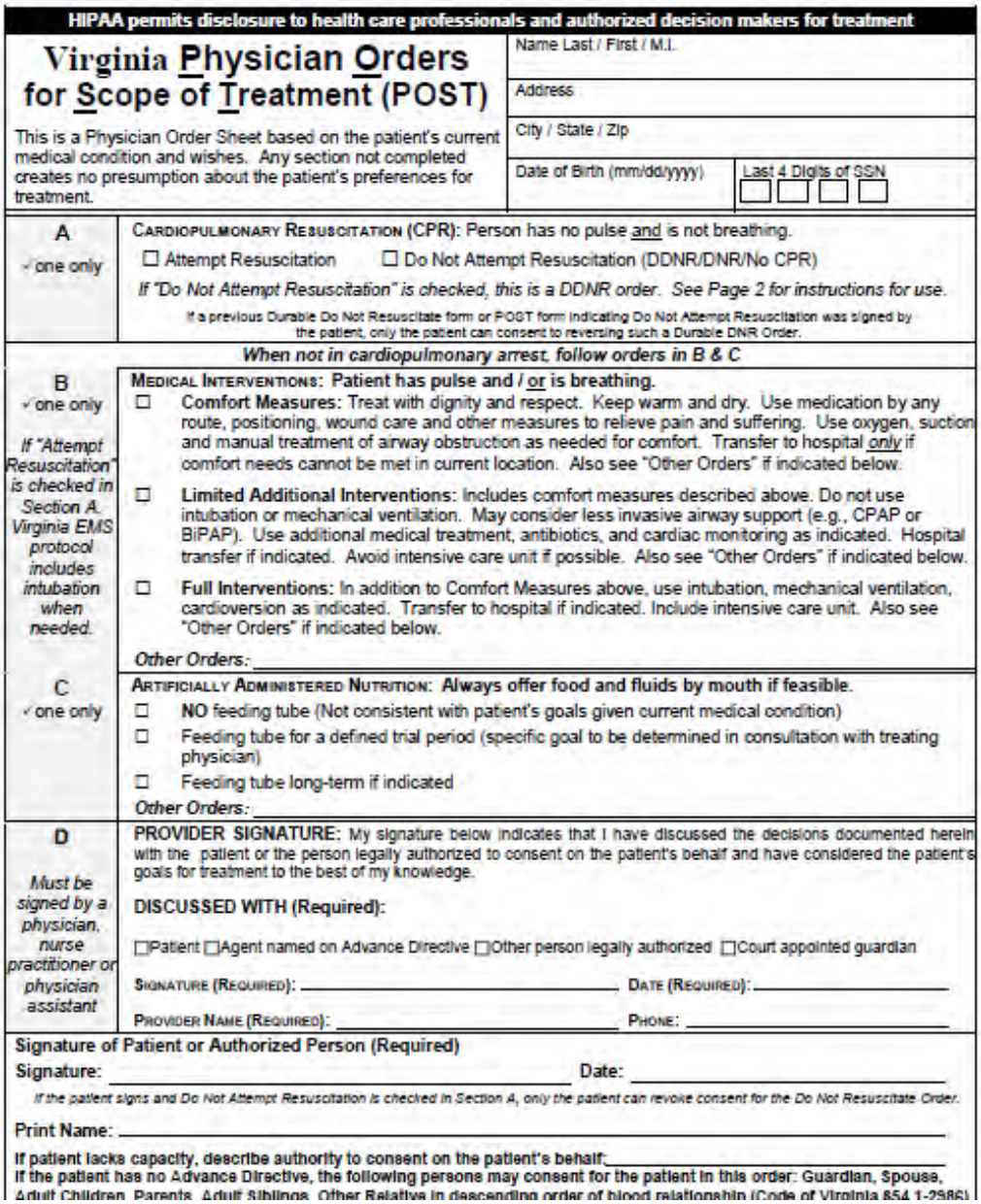
I hereby direct any and all qualified health care personnel, commencing on the effective date noted above, to withhold cardiopulmonary resuscitation (cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, and related procedures) from the patient in the event of the patient's cardiac or respiratory arrest. I further direct such personnel to provide the patient other medical interventions, such as intravenous fluids, oxygen, or other therapies deemed necessary to provide comfort care or alleviate pain.

_____	_____	_____
Physician's Printed Name	Physician's Signature	Emergency Phone Number

_____	_____
Patient's Signature	Signature of Person Authorized to Consent on the Patient's Behalf

Physician Orders for Scope of Treatment (POST) Form

Similar to the DDNR above, POST forms provide a signed physician's order for specific medical care to be provided or withheld in the event of a medical emergency. POST forms are completed with the consent of the patient or an appropriate decision-maker. When Section A is marked "Do Not Attempt Resuscitation," the POST form acts as a DDNR order specifying that cardiopulmonary resuscitation should be withheld in the event of cardiac and/or respiratory arrest. The POST form also addresses pre-arrest conditions where providers need to assess how aggressively to treat the condition. Patients or their decision-makers may choose not to receive intubation or may even choose comfort measures only. Equivalent forms are issued in other states, such as the Maryland MOLST form and the District of Columbia MOST form.



HIPAA permits disclosure to health care professionals and authorized decision makers for treatment

Virginia Physician Orders for Scope of Treatment (POST)

This is a Physician Order Sheet based on the patient's current medical condition and wishes. Any section not completed creates no presumption about the patient's preferences for treatment.

Name Last / First / M.I.

Address

City / State / Zip

Date of Birth (mm/dd/yyyy) | Last 4 Digits of SSN ☐☐☐☐

A — ✓ one only

CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing.

☐ Attempt Resuscitation ☐ Do Not Attempt Resuscitation (DDNR/DNR/No CPR)

If "Do Not Attempt Resuscitation" is checked, this is a DDNR order. See Page 2 for instructions for use.

If a previous Durable Do Not Resuscitate form or POST form indicating Do Not Attempt Resuscitation was signed by the patient, only the patient can consent to reversing such a Durable DNR Order.

When not in cardiopulmonary arrest, follow orders in B & C

B — ✓ one only

If "Attempt Resuscitation" is checked in Section A, Virginia EMS protocol includes intubation when needed.

MEDICAL INTERVENTIONS: **Patient has pulse and / or is breathing.**

☐ **Comfort Measures:** Treat with dignity and respect. Keep warm and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Transfer to hospital *only* if comfort needs cannot be met in current location. Also see "Other Orders" if indicated below.

☐ **Limited Additional Interventions:** Includes comfort measures described above. Do not use intubation or mechanical ventilation. May consider less invasive airway support (e.g., CPAP or BiPAP). Use additional medical treatment, antibiotics, and cardiac monitoring as indicated. Hospital transfer if indicated. Avoid intensive care unit if possible. Also see "Other Orders" if indicated below.

☐ **Full Interventions:** In addition to Comfort Measures above, use intubation, mechanical ventilation, cardioversion as indicated. Transfer to hospital if indicated. Include intensive care unit. Also see "Other Orders" if indicated below.

Other Orders: _____

C — ✓ one only

ARTIFICIALLY ADMINISTERED NUTRITION: **Always offer food and fluids by mouth if feasible.**

☐ **NO** feeding tube (Not consistent with patient's goals given current medical condition)

☐ Feeding tube for a defined trial period (specific goal to be determined in consultation with treating physician)

☐ Feeding tube long-term if indicated

Other Orders: _____

D

Must be signed by a physician, nurse practitioner or physician assistant

PROVIDER SIGNATURE: My signature below indicates that I have discussed the decisions documented herein with the patient or the person legally authorized to consent on the patient's behalf and have considered the patient's goals for treatment to the best of my knowledge.

DISCUSSED WITH (Required):

☐Patient ☐Agent named on Advance Directive ☐Other person legally authorized ☐Court appointed guardian

SIGNATURE (REQUIRED): _____ DATE (REQUIRED): _____

PROVIDER NAME (REQUIRED): _____ PHONE: _____

Signature of Patient or Authorized Person (Required)

Signature: _____ **Date:** _____

If the patient signs and Do Not Attempt Resuscitation is checked in Section A, only the patient can revoke consent for the Do Not Resuscitate Order.

Print Name: _____

If patient lacks capacity, describe authority to consent on the patient's behalf: _____

If the patient has no Advance Directive, the following persons may consent for the patient in this order: Guardian, Spouse, Adult Children, Parents, Adult Siblings, Other Relative in descending order of blood relationship (Code of Virginia §54.1-2986)

DNR for Procedures

A signed consent form for patients with a code status of DNR who are undergoing a medical procedure. This document allows patients or their decision-makers to specify whether and under what circumstances they wish to be resuscitated in the event of cardiopulmonary arrest during or immediately following the procedure while still in the recovery area.

INOVA

1DNRPST

You have been scheduled for the following procedure or surgery at Inova: _____

Every procedure or surgery has a chance of side effects or complications. These complications can typically be addressed during the procedure, but doing so may involve practices that might be viewed as "resuscitation" in other settings. It is the policy of Inova that you (or your legal healthcare representative) and your physician re-evaluate your DNR ("Do Not Resuscitate") order prior to any procedure so your healthcare team knows your wishes. This includes a review of your underlying condition and the reason(s) for the procedure.

It may be necessary to tailor the DNR order for a procedure requiring anesthesia with the understanding that a temporary breathing tube may be placed in addition to normal anesthetic management. All attempts will be made to remove the breathing device at the end of the procedure, but sometimes it is necessary to keep the breathing tube in for a short period after the procedure until the lungs are strong enough to safely remove it.

In consideration of a planned procedure or surgery, there are three ways in which you (or your legal healthcare representative), may address any potential event of cardiac or pulmonary arrest: (*please mark one:*)

- ☐ **Full Attempt at Resuscitation:** Appropriate resuscitation procedures will be performed to treat clinical events during the procedure.
- ☐ **Limited Attempt at Resuscitation:** Based on your goals, healthcare providers will use clinical judgment and implement limited measures to address potentially reversible conditions. This may include interventions such as: chest compressions, electrical cardiac stimulation to correct any life-threatening irregular heartbeat, and medication management of blood pressure and heart functioning.
- ☐ **No Resuscitation:** The elective placement of a breathing tube and/or normal anesthesia management will be provided, but no intervention(s) to be done in the event of cardiac or pulmonary arrest.**

*** If the patient him-or-herself signed a DDNR, and the patient is not able to make medical decisions, the No Resuscitation option must be chosen.*

Your original DNR order will again become effective (1) when discharged from the recovery area, or (2) following successful weaning from ventilator support. If you need to keep the breathing tube for a period of time after the procedure or surgery, after 24 hours physicians will reevaluate your ability to be weaned from ventilator support and discuss this with you (or your legal healthcare representative) for further guidance.

I have been given an opportunity to ask questions regarding the alteration of my existing DNR order. I agree that this form has been fully explained and that I have read it or had it read to me, and that I fully understand its contents and purpose.

If you have any questions, please take the opportunity to discuss DNR options with your physician and/or appropriate healthcare representative(s).

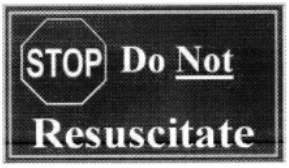
_____	_____	
Patient or Legal Representative Signature	*Date*	*Time*
_____	_____	
Physician or Witness Signature	*Date*	*Time*

Guardianship

A guardian is a person who is appointed by a court to make decisions regarding the personal and financial affairs of a person (the ward) who has been determined to be legally incompetent. A conservator is appointed specifically to manage the ward's financial affairs, and may or may not have the ability to make medical decisions. Be sure to check the paperwork authorizing the guardianship or conservatorship and ensure we have a copy of the court order or the official letter of guardianship/conservatorship scanned into the medical record. Because establishing a guardianship may remove considerable rights from an individual, it should only be considered after alternatives to guardianship have proven ineffective or are unavailable.

Retired ACP Documents

Advance care planning documents should be retired when they are no longer in force because they have expired, have been superseded by newer documents, or have been rescinded or cancelled by an appropriate party.



Durable Do Not Resuscitate Order

Virginia Department of Health

Patient's Full Legal Name JUAN SMITH **Date** 12-20-20

Physician's Order

I, the undersigned, state that I have a bona fide physician-patient relationship with the patient named above. I have certified in the patient's medical record that he/she or a person authorized to consent on the patient's behalf has directed that life-prolonging procedures be withheld or withdrawn in the event of cardiac or respiratory arrest.

I further certify (must check 1 or 2):

☒ 1. The patient is CAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment. (Signature of patient is required)

☐ 2. The patient is INCAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment because he/she is unable to understand the nature, extent or probable consequences of the proposed medical decision, or to make a rational evaluation of the risks and benefits of alternatives to that decision.

If you checked 2 above, check A, B, or C below:

☐ A. While capable of making an informed decision, the patient has executed a written advanced directive which directs that life-prolonging procedures be withheld or withdrawn.

REVOKED 3-20-21 BJP