SRMC
SOUTHSIDE REGIONAL
MEDICAL CENTER

REFERENCE GUIDE FOR
ADVANCE DIRECTIVE
DURABLE DO NOT RESUSCITATE (DDNR)
DO NOT RESUSCITATE (DNR)

WRITTEN ADVANCE DIRECTIVE may include:

instructions regarding treatment (Living Will), POA appointment, anatomical gift or research participation

In order to be valid, each of the following must be present:

- Made by adult, patient over age 18, capable of making informed decision.
- In effect when incapable of making informed decision.
- Patient has terminal condition or mental illness (if specified in advanced directive POA/agent can authorize patient's admission to mental health facility if patient deemed to have mental illness or is incapable of making informed decision)
- Signed by patient.
- Signed by two witnesses – may be spouse or blood relative. (May accept a form from another state if it is signed by patient and two witnesses)
- Does not need to be notarized.
- Copy, fax, or PDF is valid. No special form is required.

ORAL ADVANCE DIRECTIVE

In order to be valid, each of the following must be present:

- Patient over age 18, capable of making informed decision.
- Patient has terminal condition as determined by physician
- Statement made in presence of attending physician and two witnesses, over the age of 18, (may be spouse or blood relative)
- Valid only during current hospitalization.

HEALTH CARE POWER OF ATTORNEY, or AGENT, SURROGATE, PROXY

In order to be valid, each of the following must be present:

- Patient over age 18.
- Patient incapable of making an informed decision.
- Document in writing - No special form required.
- Signed by patient and
- Signed by two witnesses – may be spouse or blood relative. (May accept a form from another state if it is signed by patient and two witnesses)
- Specifies an individual to make healthcare decisions if patient is Incapable of Making an Informed Decision, as determined by attending physician and second physician.
- Does not require patient to have a terminal condition.
- May authorize admission for treatment of mental illness if specified by patient.
- Does not need to be notarized.
- Copy, fax, or PDF is valid.

DURABLE DO NOT RESUSCITATE ("DDNR")

In order to be valid, each of the following must be present:

- Valid in any setting (hospital, home, LTC, SNF etc.)
- **S**tate approved form (legible copy of form allowed) showing physician order to not resuscitate in the event of cardiac or respiratory arrest (Cannot accept a form from another state)
- Does NOT require additional written DNR order in the chart.
- Patient's signature or signature of person authorized to consent on patient's behalf.
- Physician's signature and date required as well as documentation in the medical record that the DDNR was created
- Authorized form of bracelet or necklace acceptable **if** jewelry contains:
    - The words, Do Not Resuscitate
    - The physician's name and phone number, and
    - The Virginia Durable DNR issuance date
- Does **not** expire unless revoked by patient
- For patient with valid DDNR or, DDNR jewelry, staff shall withhold or withdraw CPR unless otherwise directed by physician present at the patient's location.
- DDNR is limited to withholding CPR, comfort care should continue.

For patients suspected to have a DDNR, and are not wearing DDNR jewelry –routine assessment and resuscitation will be performed UNTIL the DDNR or DNR status is confirmed.

REVOCATION of a DDNR

In order to be valid, each of the following must be present:

- No one other than the patient may revoke a DDNR that was authorized by the patient
- DDNR can be revoked by:
    - Physical cancellation or destruction by patient.
    - Oral expression of intent to revoke by the patient.
    - Removing approved DDNR jewelry
    - Family cannot override patient wishes
    - Substitute decision maker may revoke a DDNR that he/she initiated after the patient became incapable of making his/her own decisions.

DO NOT RESUSCITATE ORDER (DNR)

In order to be valid, each of the following must be present:

- Order present in patient's chart, includes physician's signature, date, and time.
- Not on approved state form
- Applies only to current hospitalization, NOT transferrable across healthcare settings
- May be a *verbal order* issued by the physician if he/she is present at the bedside
- DNR orders are **NOT** automatically suspended during surgery or invasive procedures. The attending physician and/or surgeon and/or anesthesiologist will discuss the appropriateness of suspension with the patient or agent prior to surgery and prior to any sedation for surgery. The physician(s) will document in the medical record the time and substance of such discussion. If the DNR order or other Advance Directive is to be suspended or modified and reinstated, this must be written and signed by the attending physician and reinstated.

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.]

The powers of my agent shall include the following:

1. To consent to or refuse or withdraw consent to any type of health care, including, but not limited to, artificial respiration (breathing machine), artificially administered nutrition (tube feeding) and hydration (IV fluids), and cardiopulmonary resuscitation (CPR). This authorization specifically includes the power to consent to dosages of pain-relieving medication in excess of recommended dosages in an amount sufficient to relieve pain. This applies even if this medication carries the risk of addiction or of inadvertently hastening my death.
2. To request, receive and review any oral or written 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 as necessary to carry out my directions as stated in this advance directive.
3. To employ and discharge my health care providers.
4. To authorize my admission, transfer, or discharge to or from a hospital, hospice, nursing home, assisted living facility or other medical care facility.
5. To authorize my admission to a health care facility for treatment of mental illness as permitted by law. (If I have other instructions for my agent regarding treatment for mental illness, they are stated in a supplemental document.)
6. To continue to serve as my agent if I object to the agent's authority after I have been determined to be incapable of making an informed decision.
7. To authorize my participation in any health care study approved by an institutional review board or research review committee according to applicable federal or state law if the study offers the prospect of direct therapeutic benefit to me.
8. To authorize my participation in any health care study approved by an institutional review board or research review committee according to applicable federal or state law that aims to increase scientific understanding of any condition that I may have or otherwise to promote human well-being, even though it offers no prospect of direct benefit to me.

9. To make decisions regarding visitation during any time that I am admitted to any health care facility, consistent with the following directions:

_____

10. To take any lawful actions that may be necessary to carry out these decisions, including the granting of releases of liability to medical providers.

ADDITIONAL POWERS OR LIMITATIONS, IF ANY:

_____

_____

_____

SECTION II: MY HEALTH CARE INSTRUCTIONS

[YOU MAY USE ANY OR ALL OF PARTS 1, 2 OR 3 IN THIS SECTION TO DIRECT YOUR HEALTH CARE EVEN IF YOU DO NOT HAVE AN AGENT. IF YOU CHOOSE NOT TO PROVIDE WRITTEN INSTRUCTIONS, DECISIONS WILL BE BASED ON YOUR VALUES AND WISHES, IF KNOWN, AND OTHERWISE ON YOUR BEST INTERESTS. IF YOU ARE AN EYE, ORGAN OR TISSUE DONOR, YOUR INSTRUCTIONS WILL BE APPLIED SO AS TO ENSURE THE MEDICAL SUITABILITY OF YOUR ORGANS, EYES AND TISSUE FOR DONATION.]

1. I provide the following instructions in the event my attending physician determines that my death is imminent (very close) and medical treatment will not help me recover:

[CHECK ONLY 1 BOX IN THIS PART 1.]

❒ 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. (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)

❒ [YOU MAY WRITE HERE YOUR OWN INSTRUCTIONS ABOUT YOUR CARE WHEN YOU ARE DYING, INCLUDING SPECIFIC INSTRUCTIONS ABOUT TREATMENTS THAT YOU DO WANT, IF MEDICALLY APPROPRIATE, OR DON'T WANT. IT IS IMPORTANT THAT YOUR INSTRUCTIONS HERE DO NOT CONFLICT WITH OTHER INSTRUCTIONS YOU HAVE GIVEN IN THIS ADVANCE DIRECTIVE.]:

_____

_____

_____

_____

2. I provide the following instructions 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:

[CHECK ONLY 1 BOX IN THIS PART 2.]

❒ 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. (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. (OR)

❒ [YOU MAY WRITE HERE YOUR INSTRUCTIONS ABOUT YOUR CARE WHEN YOU ARE UNABLE TO INTERACT WITH OTHERS AND ARE NOT EXPECTED TO RECOVER THIS ABILITY. THIS INCLUDES SPECIFIC INSTRUCTIONS ABOUT TREATMENTS YOU DO WANT, IF MEDICALLY APPROPRIATE, OR DON'T WANT. IT IS IMPORTANT THAT YOUR INSTRUCTIONS HERE DO NOT CONFLICT WITH OTHER INSTRUCTIONS YOU HAVE GIVEN IN THIS ADVANCE DIRECTIVE.]

_____

_____

_____

_____

3. I provide the following other instructions concerning my health care:

[YOU MAY WRITE HERE STATEMENTS AND INSTRUCTIONS ABOUT TREATMENTS THAT YOU DO WANT, IF MEDICALLY APPROPRIATE, OR ABOUT TREATMENTS YOU DO NOT WANT UNDER SPECIFIC CIRCUMSTANCES OR ANY CIRCUMSTANCES. IT IS IMPORTANT YOUR INSTRUCTIONS HERE DO NOT CONFLICT WITH OTHER INSTRUCTIONS YOU HAVE GIVEN IN THIS ADVANCE DIRECTIVE.]

SECTION III: ANATOMICAL GIFTS

(YOU MAY USE THIS DOCUMENT TO RECORD YOUR DECISION TO DONATE YOUR ORGANS, EYES AND TISSUES OR YOUR WHOLE BODY AFTER YOUR DEATH. IF YOU DO NOT MAKE THIS DECISION HERE OR IN ANY OTHER DOCUMENT, YOUR AGENT CAN MAKE THE DECISION FOR YOU UNLESS YOU SPECIFICALLY PROHIBIT HIM/HER FROM DOING SO, WHICH YOU MAY DO IN THIS OR SOME OTHER DOCUMENT. CHECK ONE OF THE BOXES BELOW IF YOU WISH TO USE THIS SECTION TO MAKE YOUR DONATION DECISION.)

❒ 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. I understand that I may register my directions at the Department of Motor Vehicles or directly on the donor registry, www.DonateLifeVirginia.org, and that I may use the donor registry to amend or revoke my directions; OR

❒ I donate my whole body for research and education.

[Write here any specific instructions you wish to give about anatomical gifts.]

AFFIRMATION AND RIGHT TO REVOKE: By signing below, I indicate that I understand this document and that 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.

Date Signature of Declarant

The declarant signed the foregoing advance directive in my presence. [TWO ADULT WITNESSES NEEDED]

Witness Signature Witness Printed

Witness Signature Witness Printed

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. It is your responsibility to provide a copy of your advance directive to your treating physician. You also should provide copies to your agent, close relatives and/or friends. For information on storing this advance directive in the free Virginia Advance Health Directive Registry, go to http://www.VirginiaRegistry.org. ▲❋❋