Fredericksburg Ambulatory Surgery Center

MARY WASHINGTON HEALTHCARE

ADVANCE DIRECTIVE NOTIFICATION:

All patients have the right to participate in their own health care decisions and to make Advance Directives or to execute Power of Attorney that authorize others to make decisions on their behalf based on the patient's expressed wishes when the patient is unable to make decisions or unable to communicate decisions. This Surgery Center respects and upholds those rights.

However, unlike in an acute care hospital setting, the Surgery Center does not routinely perform "high risk" procedures. Most procedures performed in this facility are considered to be of minimal risk. Of course, no surgery is without risk. You will discuss the specifics of your procedure with your physician who can answer your questions as to its risks, your expected recovery, and care after surgery.

Therefore, it is our policy, regardless of the contents of any Advance Directive or instructions from a health care surrogate or attorney-in-fact, that if an adverse event occurs during your treatment at this facility, we will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital, further treatments or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, Advance Directive, or healthcare Power of Attorney. Your agreement with this facility's policy will not revoke or invalidate any current health care directive or health care power of attorney.

If you wish to complete an Advance Directive, copies of the official state forms are available at our facility, or you may print and complete the following pages and bring them with you on the day of your procedure.

Advance Medical Directive made this_____ day of_____, _____.

I, _____, willingly and voluntarily make known my wishes in the event that I am incapable of making an informed decision, as follows:

The term *"health care"* means: the furnishing of services to any individual for the purpose of preventing, alleviating, curing or healing human illness, injury, or physical disability, including, but not limited to medications; surgery; blood transfusions; chemotherapy; radiation therapy; admission to a hospital, nursing home, assisted living facility or other health care facility; psychiatric or other mental health treatment; and life-prolonging procedures and palliative care.

The phrase *"incapable of making an informed decision"* means: unable to understand the nature, extent and probable consequences of a proposed health care decision; unable to make a rational evaluation of the risks and benefits of a proposed health care decision as compared with the risks and benefits of alternatives to that decision; or unable to communicate such understanding in any way.

The determination that I am incapable of making an informed decision shall be made by my attending physician and a capacity reviewer, if certification by a capacity reviewer is required by law, after a personal examination of me and shall be certified in writing. Such certification shall be required before health care is provided, continued, withheld, or withdrawn; before any named agent shall be granted authority to make health care decisions on my behalf; and before, or as soon as reasonably practicable after health care is provided, continued, withheld, or withdrawn; and every 180 days thereafter while the need for health care continues.

If, at any time, I am determined to be incapable of making an informed decision, I shall be notified, to the extent that I am capable of receiving such notice, that such a determination has been made before health care is provided, continued, withheld or withdrawn. Such notice also shall be provided, as soon as practical, to my named agent or person authorized under Virginia law to make health care decisions on my behalf. If I am later determined to be capable of making an informed decision by a physician, in writing, upon personal examination, the any further health care decisions will require my informed consent.

Section 1: I understand that my advance directive may include my choices regarding end-of-life care.

Instructions on End-of-Life Care: Living Will

(Cross through this section if you do not wish to provide instructions about your health care if you have a terminal condition.)

If at any time my attending physician should determine that I have a terminal condition where the application of **life-prolonging procedures (** including artificial respiration, cardiopulmonary resuscitation, artificially administered nutrition and artificially administered hydration) would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

In the absence of my ability to give directions regarding the use of such life-prolonging 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 health care and acceptance of the consequences of such refusal.

(Cross through options I and II below if you do not wish to provide additional instructions about end of life care.)

I specifically direct that the following be provided to me:

Option I: Life-prolonging procedures (regarding artificial respiration, CPR, artificially administered nutrition and artificially administered hydration). I direct that:_____
_____
_____

Option II: Care other than life-prolonging procedures for a terminal condition. I direct that:_____
_____
_____

Section 2: I understand that my advance directive may include the selection of an agent to make decisions on my behalf regarding my health care.
(Cross through sections I and II below if you do not wish to appoint an agent to make health care decisions for you)

I. Appointment of Agent:

I hereby appoint the following as my primary agent to make health care decisions on my behalf as authorized in this document.

Primary Agent	Telephone	Fax
Address	Email	

If the above named agent is not reasonably available or is unwilling to act as my agent, then I appoint the following as successor agent:

Successor Agent	Telephone	Fax
Address	Email	

I hereby grant my agent named above full power and authority to make health care decisions on my behalf as described below whenever I have been determined to be incapable of making an informed decision. My agent's authority is effective as long as I am incapable of making an informed decision.

In exercising the power to make health care decisions on my behalf, my agent shall follow my desires and preferences as stated in this document or as otherwise known to my agent. My agent shall be guided by my medical diagnosis and prognosis and any information provided by my physicians as to the intrusiveness, pain, risks and side effects associated with treatment or non-treatment. My agent shall not make any decision regarding my health care which he or she knows, or upon reasonable inquiry ought to know, is contrary to my religious beliefs or my basic values, whether expressed orally or in writing. If my agent cannot determine what health care choice I would have made on my own behalf, then my agent shall make a choice for me based on what he or she believes to be in my best interests.

Further, my agent shall not be liable for the costs of health care that he or she authorizes, based solely on that authorization.

II. Powers of My Agent:

The powers of my agent shall include the following:
(Cross through any powers in this section that you do not want to give your agent and add any powers or instructions that you do want to give to your agent)

A. To consent to or refuse or withdraw consent to any type of health care, treatment, surgical procedure, diagnostic procedure, medication and the use of mechanical or other procedures that affect any bodily function, including, but not limited to, artificial respiration, artificially administered nutrition and hydration and cardiopulmonary resuscitation. This authorization specifically includes the power to consent to 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 inadvertently hastens my death;

B. 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.

C. To employ and discharge my health care providers.

D. To authorize my admission to or discharge (including transfer to another facility) from any hospital, hospice, nursing home, assisted living facility or other medical care facility.

Sections E and F refer to authorized admission to a health care facility for mental illness:

E. To authorize my admission to a health care facility for the treatment of mental illness for no more than 10 calendar days **provided that I do not protest** the admission and provided that a physician on the staff of or designated by the proposed admitting facility examines me and states in writing that I have a mental illness, that I am incapable of making an informed decision about my admission, that I need treatment in the facility, and to authorize my discharge (including transfer) from the facility.

F. To authorize my admission to a health care facility for the treatment of mental illness for no more than 10 calendar days, **even over my protest**, if a physician on the staff or designated by the proposed admitting facility examines me and states in writing that I have a mental illness, that I am incapable of making an informed decision about my admission, that I need treatment in the facility, and to authorize my discharge (including transfer) from the facility.
Physician attestation: I am the physician or licensed clinical psychologist of the declarant of this advance directive. I hereby attest that I believe the declarant to be presently capable of making an informed decision and that the declarant understand the consequences of this provision of this advance directive.

_____

Physician Signature Date

_____

Physician Name printed

G. To authorize the following specific types of health care identified in this advance directive, **even if I protest.** *(Specifically cross-reference any applicable sections of this advance directive.)*

_____
_____
_____

Physician attestation: I am the physician or licensed clinical psychologist of the declarant of this advance directive. I hereby attest that I believe the declarant to be presently capable of making an informed decision and that the declarant understands the consequences of this provision of this advance directive.

_____

Physician Signature Date

_____

Physician Name printed

H. To continue to serve as my agent **even if I protest** the agent's authority after I have been determined to be incapable of making an informed decision.

I. To make decisions about who may visit me during any time that I am admitted to any health care facility, consistent with the following directions:

_____
_____

Sections J and K refer to authorized participation in health care studies:

J. To authorize my participation in a health care study approved by an institutional review board or research review committee (pursuant to applicable federal or state law) **if** the study offers the prospect of direct therapeutic benefit to me.

K. To authorize my participation in any health care study approved by an institutional review board or research review committee (pursuant 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** the study offers no prospect f direct benefit to me.

L. 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/limits/instructions:
I further instruct my agent as follows:

_____
_____
_____

Section 3: I understand that my advance directive sets forth my choices regarding my health care and that it shall not terminate in the event of my disability.

Health Care Instructions:

(Cross through sections below if you do not wish to give specific instructions about your health care)

I specifically direct that I receive the following health care if it is medically appropriate under the circumstances as determined by my attending physician:_____
_____
_____

I specifically direct that the following health care not be provided to me under the following circumstances: _____
_____
_____
_____

Section 4: I understand that my advance directive may include the selection of an agent to set forth my choices regarding anatomical gifts, organ, tissue and eye donations.

Appointment of an Agent to Make an Anatomical Gift or Organ, Tissue, or Eye Donation

(Cross through this section if you do not wish to appoint an agent to make an anatomical gift or any organ, tissue or eye donation for you)

Upon my death, I direct that an anatomical gift of all of my body or certain organ, tissue or eye donations be made pursuant to applicable Virginia law and in accordance with my directions below, if any. I hereby appoint as my agent to make such anatomical gift or organ, tissue or eye donation following my death (choose one):

☐ The same agent (and alternate) named on page 2 of this document; **OR**

☐ Agent listed below.

_____
Name of Agent Phone Fax

_____
Address Email

I further direct that:_____
_____
_____

(Declarant's directions, if any concerning anatomical gift or organ, tissue or eye donation)

(You must sign below in the presence of two witnesses.)

Affirmation and Right to Revoke:

By signing below, I state 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 at any time (i) with a signed, date writing; (ii) by physical cancellation or destruction of this advance directive by myself or by directing someone else to destroy it in my presence; **or** (iii) by my oral expression of intent to revoke.

_____

Signature of Declarant

_____ _____

Witness Witness

This form, with slight variations, is suggested for use by the VA Hospital and Healthcare Assn. and satisfies the requirements of VA law. You may complete all or any of the sections of the form. If you have legal questions about this document, or would like to develop a different form to meet your particular needs, you are urged to speak with your attorney. Under VA law, it is your responsibility to provide a copy of your Advance Medical Directive to your attending physician. It is recommended that you also provide copies to your agent, close relatives, and friends.