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Department of Veterans Affairs

VA ADVANCE DIRECTIVE: DURABLE POWER OF ATTORNEY FOR HEALTH CARE AND LIVING WILL

This advance directive form is an official document where you can write down your preferences about your medical care. If some day you become unable to make health care decisions for yourself, this advance directive can help guide the people who will make decisions for you. You can use this form to name specific people to make health care decisions for you and/or to describe your preferences about how you want to be treated. When you complete this form, it is important that you also talk to your doctor, your family, or others who may be involved in decisions about your care, to make sure they understand what you meant when you filled out this form. A health care professional can help you with this form and can answer any questions you might have. If more space is needed for any part of this form, you may attach additional pages. Be sure to initial and date every page that you attach.

PART I: PERSONAL INFORMATION

NAME *(Last, First, Middle)*	SOCIAL SECURITY NUMBER

STREET ADDRESS

CITY, STATE AND ZIP CODE

HOME PHONE WITH AREA CODE	WORK PHONE WITH AREA CODE	MOBILE PHONE WITH AREA CODE

Privacy Act Information and Paperwork Reduction Act Notice

The information requested on this form is solicited under the authority of 38.C.F.R. §17.32. It is being collected to document your preferences about your medical care in the event you are no longer able to express these preferences. The information you provide may be disclosed outside the VA as permitted by law; possible disclosures include those described in the "routine uses" identified in the VA system of records 24VA19, Patient Medical Record-VA, published in the Federal Register in accordance with the Privacy Act of 1974. This is also available in the Compilation of Privacy Act Issuances via online GPO access at http://www.gpoaccess.gov/privacyact/index.html. Completion of this form is voluntary; however, without this information VA health care providers may have less information about your preferences. Failure to furnish the information will have no adverse effect on any other benefits which you may be entitled to receive. The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of this Act. The public reporting burden for this collection of information is estimated to average 30 minutes, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. No person will be penalized for failing to furnish this information if it does not display a currently valid OMB control number.

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PART II: DURABLE POWER OF ATTORNEY FOR HEALTH CARE

This section of the advance directive form is called a Durable Power of Attorney for Health Care. This section of the form allows you to appoint a specific person to make health care decisions for you in case you become unable to make decisions for yourself. This person will be called your Health Care Agent. Your Health Care Agent should be someone you trust, who knows you well, and is familiar with your values and beliefs. If you become too ill to make decisions for yourself, your Health Care Agent will have the authority to make all health care decisions for you, including decisions to admit you to and discharge you from any hospital or other health care institution. Your Health Care Agent can also decide to start or stop any type of clinical treatment, and can access your personal health information, including information from your medical records. **NOTE: Information about whether you have been tested for HIV or treated for AIDS, sickle cell anemia, substance abuse or alcoholism cannot be shared with your Health Care Agent unless you give special written consent. Ask your VA health care provider for the form you must sign (VA Form 10-5345) if you wish to give permission for VA to share this information with your Health Care Agent.**

A - HEALTH CARE AGENT

Initial the box next to your choice. *Choose only one.*

Initials	
	I do not wish to designate a Health Care Agent at this time. (Skip this section and go to Part III, page 3.)
	I appoint the person named below to make decisions about my health care if there ever comes time when I cannot make those decisions.

Name *(Last, First, Middle)*	Relationship

Street Address	City, State and Zip Code

Home Phone with Area Code	Work Phone with Area Code	Mobile Phone with Area Code

B - ALTERNATE HEALTH CARE AGENT

Complete this section if you want to appoint a second person to make health care decisions for you in case the first person you appointed is unavailable.

Initials	
	If the person named above cannot or will not make decisions for me, I appoint the person named below to act as my Health Care Agent.

Name *(Last, First, Middle)*	Relationship

Street Address	City, State and Zip Code

Home Phone with Area Code	Work Phone with Area Code	Mobile Phone with Area Code

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PART III: LIVING WILL

This section of the advance directive form is called a Living Will. This section of the form allows you to write down how you want to be treated in case you become unable to make decisions for yourself. Its purpose is to inform the people who will be making decisions about your care.

A - SPECIFIC PREFERENCES ABOUT LIFE-SUSTAINING TREATMENTS

This section gives you a place to indicate your preferences about life-sustaining treatments in particular situations. Some examples of life-sustaining treatments are CPR (cardiopulmonary resuscitation), breathing machine (mechanical ventilation), kidney dialysis, feeding tubes (artificial nutrition and hydration), and medicines to fight infection (antibiotics). Think about each situation described on the left and ask yourself, "In that situation, would I want to have life-sustaining treatments?" Place your initials in the box that best describes your treatment preference. ***You may complete some, all, or none of this section. Choose only one box for each statement.***

	Yes. I would want to have life-sustaining treatments.	It would depend on the circumstances.	**No.** I would not want to have life-sustaining treatments.
If I am unconscious, in a coma, or in a persistent vegetative state and there is little or no chance of recovery	Initials	Initials	Initials
If I have permanent severe brain damage (for example, severe dementia) that makes me unable to recognize my family or friends	Initials	Initials	Initials
If I have a permanent condition that makes me completely dependent on others for my daily needs (for example, eating, bathing, toileting)	Initials	Initials	Initials
If I am confined to bed and need a breathing machine for the rest of my life	Initials	Initials	Initials
If I have pain or other severe symptoms that cannot be relieved	Initials	Initials	Initials
If I have a condition that will cause me to die very soon, even with life-sustaining treatments	Initials	Initials	Initials

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NAME *(Last, First, Middle)*	SOCIAL SECURITY NUMBER

PART III: LIVING WILL (Cont'd)

B - ADDITIONAL PREFERENCES

You may use this space to write any other preferences about your health care that are important to you and that are not described elsewhere in this document. This may include general preferences about how you would like to be cared for, or specific requests. For example, you might have clear opinions about whether you would want a particular treatment (for example, a feeding tube or blood transfusions). You might want to comment on treatment of pain, or whether you would want life-sustaining treatments on a trial basis. Or you might want to write about your preferences regarding treatment of mental illness.

C - HOW STRICTLY YOU WANT YOUR PREFERENCES FOLLOWED

Initial the box next to the statement that reflects how strictly you want your preferences to be followed. *Choose only one.*

Initials	I want my preferences, expressed above in this Living Will, to serve as a *general guide*. I understand that in some situations the person making decisions for me may decide something different from the preferences I express above, if they think it is in my best interest.
Initials	I want my preferences, expressed above in this Living Will, to be followed strictly, even if the person who is making decisions for me thinks this is not in my best interest.

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PART IV: SIGNATURES

A - YOUR SIGNATURE

By my signature below, I certify that this form accurately describes my preferences.

SIGNATURE	DATE

B - WITNESSES' SIGNATURES

Two people must witness your signature. *VA employees of the Chaplain Service, Psychology Service, Social Work Service, or nonclinical employees (e.g., Medical Administration Service, Voluntary Service or Environmental Management Service) may serve as witnesses. Other individuals employed by your VA facility may not sign as witnesses to the advance directive unless they are your family members.*

Witness #1

I personally witnessed the signing of this advance directive. I am not appointed as Health Care Agent in this advance directive. I am not financially responsible for the care of the person making this advance directive. To the best of my knowledge, I am not named in the person's will.

SIGNATURE	Date

Name *(Printed or Typed)*

Street Address

City, State and Zip Code

Witness #2

I personally witnessed the signing of this advance directive. I am not appointed as Health Care Agent in this advance directive. I am not financially responsible for the care of the person making this advance directive. To the best of my knowledge, I am not named in the person's will.

SIGNATURE	Date

Name *(Printed or Typed)*

Street Address

City, State and Zip Code

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PART V: SIGNATURE AND SEAL OF NOTARY PUBLIC *(Optional)*

This VA Advance Directive form does not have to be notarized to be valid in VA facilities. However, you may need to have this document notarized for it to be recognized outside the VA health care setting. Space for a Notary's signature and seal is included below.

On this _____ day of _____ , in the year of _____ , personally appeared before me _____ , known by me to be the person who completed this document and acknowledged it as their free act and deed. IN WITNESS WHEREOF, I have set my hand and affixed my official seal in the County of _____ , State of _____ , on the date written above.

Notary Public _____Commission Expires _____.

[SEAL]