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Department of Veterans Affairs

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

This form is a tool to document or capture a patient's wishes regarding a designated health care agent and future treatment preferences. This form is a tool, not an end in itself. The form does not substitute for comprehensive dialogue with the patient. It is expected that the health care professional assisting the patient will bring up for discussion other possible end stage scenarios, as appropriate. Supplemental pages may be appended as necessary.

I, _____ write this document as a directive regarding my health care. I have put my initials by the choices I want.
(Print or type patient's name and social security number)

Part I. - Durable Power of Attorney for Health Care (DPAHC)

Initials	
	I appoint this person to make decisions about my health care if there ever comes a time when I cannot make those decisions myself.

Name	
Street Address	
City, State and ZIP Code	
Work Telephone Number with Area Code	*Home Telephone Number with Area Code*

If the person above cannot or will not make decisions for me, I appoint this person:

Name	
Street Address	
City, State and ZIP Code	
Work Telephone Number with Area Code	*Home Telephone Number with Area Code*

Initials	
	I have notified the individuals listed above of my decision.
Initials	I have not appointed anyone to make health care decisions for me in this or any other documents.

Part II. - Living Will

These are my, _____ wishes for my
(Print or type patient's name and social security number)

future health care if there ever comes a time when I can't make these decisions for myself. I want the person I appointed as my Health Care Agent (HCA), my doctors, my family and others to be guided by the decisions I have made below.

A. Life-Sustaining Treatments

Initials

If I should have an incurable or irreversible condition that will cause my death, or am in a state of permanent unconsciousness from which, to a reasonable degree of medical certainty there can be no recovery, it is my desire that my life not be artificially prolonged by administration of "life-sustaining" procedures. If, at that time, I am unable to participate in decisions regarding my medical treatment, I direct my physician to withhold or withdraw procedures that merely prolong the dying process and are not necessary to my comfort or freedom from pain.

B. Treatment Preferences/Other Directions

Initials

You have the right to be involved in all decisions about your health care. If you have wishes not covered in other parts of this document, please indicate them here. Treatments or situations you may wish to consider include, but are not limited to: Transfusion, dialysis, CPR, artificial nutrition and hydration, mechanical breathing, pain medications, antibiotics, and a time-limited trial of a given therapy.

Part III. - Signatures

A. Your signature - By my signature below I show that I understand the purpose and the effect of this document.

Signature	*Date*
Name (Printed or Typed)	
Street Address	
City, State and ZIP Code	

B. Your Witnesses' Signatures

I am not, to the best of my knowledge, named in the person's will. I am not the person appointed as Health Care Agent (HCA) in this advance directive. I am not a health care provider (or an employee of the health care provider), or financially responsible for the patient's care, who is now, or has been in the past, responsible for the care of the person making this advance directive. (Exception: where other witnesses are not reasonably available, employees of the Chaplain Service, Psychology Service, Social Work Service, or non- clinical employees such as Voluntary Service or Environmental Management Service may serve as witnesses.)

Witness #1: I personally witnessed the signing of this advance directive.

Signature	*Date*
Name (Printed or Typed)	
Street Address	
City, State and ZIP Code	

Witness #2: I personally witnessed the signing of this advance directive.

Signature	*Date*
Name (Printed or Typed)	
Street Address	
City, State and ZIP Code	

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 25 minutes per response, 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. Response to this is voluntary and failure to furnish this information will have no effect on any of your applications for benefits. This form is to document a patient's specific instructions about health care to be carried out in the event the patient is no longeer competent or able to give those instructions or make those choices verbally.