DOWNLOAD COVERSHEET:

This is a standard advance directive for your state, made available to you as a courtesy by Lifecare Directives, LLC. You should be aware that extensive research has demonstrated that there are significant drawbacks to using a very limited standard document. As one researcher has noted, "the development of statutory forms occurs in the legislative arena, [so] their content is the result of a political rather than a 'scientific' process." Because of "political compromise, ...many of the forms ultimately passed by the legislatures are not optimal from a consumer perspective" (see: Hoffmann, Diane E; Zimmerman, S; Tompkins, C. The dangers of directives, or the false security of forms. *Journal of Law, Medicine & Ethics*. 1996;24(1) (Spring):5-17).

American Bar Association concurs, noting that "The statutory advance directive is not necessarily the exclusive, or even the best, pathway for individuals to follow," and suggesting that revised and enhanced documents "may be especially helpful as a...replacement for statutory forms where restrictions in a statutory directive prevents the individual from fully expressing his or her wishes" (see: American Bar Association. (1991). *Patient Self Determination Act State Law Guide*. Government printing office, Washington, DC).

Lifecare Directives staff have reviewed more than 6,000 medical, legal, academic, and news media articles on advance directives, as well as reviewing hundreds of document forms. They have also conducted formal research with scores of medical, legal, and academic processionals along with more than 1,000 lay public participants. From this process, more than 30 additional key living will and medical power of attorney enhancements have been identified that should be included in any living will (or "health care instruction" or "declaration") and medical power of attorney (or "proxy") forms that you may use.

Please consider obtaining the *Lifecare Advance Healthcare Directive* to obtain these important additions and benefits. To better understand the important enhancements available through this combined living will and medical power of attorney, you may wish to obtain the booklet, "*Should I Use a Shorter Standard Directive?*" available through Lifecare Directives, LLC.

If you have any other questions about this document or other Lifecare resources, please do not hesitate to contact our staff who will make every effort to fully respond your inquiries and address any questions you may have. We can be reached at the following:

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~ Lifecare Directives ~

Standard Advance Directive

of the

Veterans Administration

Regulation Compliant
Advance Directive for
Health Care Choices

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Standard Advance Directive

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Important Notice:

An advance directive is not a substitute for medical, legal or other necessary advice or direction. This document should not be construed as offering counseling, medical, legal, financial, or estate planning or advice, nor any other similar guidance or direction. Such counsel should be obtained from qualified, certified, and licensed professionals in your locale who are experienced in the specific areas of concern. Completion of this document constitutes acceptance of its content both in whole and in part, as well as a determination of its utility for the purposes indicated. Lifecare Directives, LLC, and all involved in this document's design, publication, and distribution assume no liability for its use, including that which may arise from omissions, technical inaccuracies, and typographical errors. Diligent efforts notwithstanding, this document is not warrantied to be in compliance with state and local laws. All warranties, including those of merchantability, fitness for a particular purpose, and non-infringement are expressly disclaimed. The utilizer agrees to seek appropriate outside review prior to completion. The utilizer and all heirs, assigns, designees, devisees, representatives, and all others involved, agree to assume all liability for its use and any subsequent outcomes, and to release and hold harmless all involved in its design, publication, advertising and distribution. The utilizer also agrees that any physician, health care provider, agent, proxy, surrogate, representative, mediator, court officer, and all others relying on the document's content are similarly free of all liability, when they act in good faith and with due diligence to follow the recorded wishes and directions.

Veterans Administration
Advance Health Care Directive
For Use in VA Facilities

_____ _____

Print Full Name *Date of Birth*

Your right *(when age 18 or older): To Document Your Personal Wishes, and to have these wishes followed ~~*

The Veterans Administration has provided guidelines for the construction of both a living will and a Health Care Power of Attorney for use by veterans. Collectively, these documents are known as "advance directives." As the content of these documents was designed by the Veterans Administration, each document is in compliance with all applicable guidelines.

It should be noted that the Code of Federal Regulations requires the VA to resolve any conflict between a VA advance directive and "those state laws regarding the validity of the advance directive by following the law of the State" *(Title 38, Chapter 1, §17.32)*. Consequently, it may be better complete a State-specific advance directive, rather than this VA version. See "www.lifecaredirectives.com" for state-specific directives. Consult with your physician at a local VA facility for further advice and direction.

There is an introduction to each that summarizes the scope and purpose of the documents, as well as providing further directions for completion. Read them carefully to ensure that your advance directives are fully and properly filled out.

Understanding Your Directive

To make the *best* choices for your medical care, your physician needs to know *your* wishes. In fact, the law requires doctors to seek your permission before giving you *any* treatment. However, if you are ever unable to make decisions due to severe illness or injury, this may not be possible. Completing this Directive will help your family and physicians know who should speak for you, and understand what you want if you cannot make this known yourself.

You can **revoke** (cancel) this directive at ***any*** time by: **1**) writing "revoked" across the front of the directive, followed by your signature and date, and the signature of at least one witness aged 18 years or older ; or **2**) by completing a Notice of Revocation; or **3**) by *telling* an adult witness that you want it revoked (who must then sign and date a statement, which becomes effective only when given to your doctor or health care provider); or **4**) *by simply completing a new directive* in which you state that any prior directive is no longer valid (as is already stated in this directive).

You can **limit** your directive and the authority of anyone named in it, but *no changes are recommended after the document is witnessed*. Any scope-of-authority or content changes needed *after* your directive has been witnessed should be made by completing a new directive. First-time changes can be made by lining out anything in the directive and writing "deleted" beside that clause or section (or initialing above any word(s) you have lined out), followed by your signature, and the signature of at least one of the persons serving as a witness to this document, placed in the margin immediately beside the change.

If you are **unable to write**, you may tell your directive witnesses what you want to have excluded, limited, or added to this directive. They must then sign, date, witness and/or notarize the statement of the limitations and exclusions as you have described them. Remember, unless you direct otherwise, this directive will **only** be used to guide your family and doctors if you are unable to make and communicate medical treatment decisions for yourself.

Instructions for Completing the Directive:

This directive is written in two parts. While it is best if you fill out the whole document, you may choose to complete only ***Section I***, leaving just a statement of your values and wishes. Or you may complete only ***Section II***, just naming someone to speak for you. However, this may leave your family and others without any evidence to support your wishes in the future, or leave them unsure who is to make decisions and speak for you. Thus, omitting either section may cause your loved ones difficulty if they must eventually make medical choices in your behalf. So, you are strongly encouraged to complete the entire directive.

To complete each document, you should ***initial*** in the underlined spaces provided beside all the questions that are asked, and fill in any blank lines as directed. Feel free to write "No," "None," or "Does Not Apply" in areas that would otherwise be left blank.

Instructions and Definitions for the
VA Advance Directive *(VA Form 10-0137)*

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1. **Introduction**. This combined Durable Power of Attorney for Health Care and Living Will permits you to specify certain treatments you may or may not want. With this form, you can:
    a. Appoint someone to make health care decisions for you if, in the future, you become unable to make those decisions for yourself and/or
    b. Indicate what medical treatment(s) you do or do not want if in the future you are unable to make your wishes known.

2. **Instructions for Completion**:
    a. Read each section carefully.
    b. Talk to the person(s) you plan to appoint to make sure that they understand your wishes, and are willing to take the responsibility.
    c. Place the *initials* of your name in the blank before those choices you want to make under parts 1 and 2 of VA Form 10-0137.
    d. Add any special instructions in the blank spaces provided. If you need more space for

additional comments, you may use a separate sheet of paper; but you must indicate on the form that there are additional pages to your advance directive.

e. Sign the form and have it witnessed.

f. Keep the original for yourself.

g. Give a copy of this entire form to all of the following people: your doctor or your nurse, the person you appoint to make your health care decisions for you, your family, and anyone else who might be involved in your care.

h. Remember that you may change or cancel this document at any time.

3. **Definitions** (*words you need to know*):

a. **Advance Directive.** A written document that tells what you want or do not want, if you become unable to make your wishes about health care treatments known.

b. **Artificial Nutrition and Hydration.** When synthetic food (or nutrients) and water are fed to you through a tube inserted through your nose into your stomach or into the intestine directly or into a vein.

c. **Comfort Care.** Care that helps to keep you comfortable but does not cure your disease. Bathing, turning, pain medication, keeping your lips and mouth moist and pain medications are examples of comfort care.

d. **Cardiopulmonary Resuscitation (CPR).** Treatment to try and restart a person's breathing or heartbeat. CPR may be done by breathing into your mouth, pushing on your chest, by putting a tube through your mouth or nose into your throat, administering medication, giving electric shock to your chest, or by other means.

e. **Durable Power of Attorney for Health Care.** A document that appoints a specific individual to make health care decisions for you if you become unable to make those decisions for yourself.

f. **Life-sustaining Treatment.** Any medical treatment that is used to delay the moment of death. A breathing machine (ventilator), CPR, and artificial nutrition and hydration are examples of life-sustaining treatments.

g. **Living Will.** Instructions you have made in advance that tell what medical treatment you do or do not want if you become unable to make your wishes known.

h. **Permanent Vegetative State** When a person is unconscious with no hope of regaining consciousness even with medical treatment. The body may move and eyes may be open, but as far as anyone can tell, the person can't think or communicate.

i. **Surrogate Decision-maker**. This is an individual, organization or other body authorized to make health care decisions for you if you are unable to do so yourself.

VA ADVANCE DIRECTIVE:
LIVING WILL AND
DURABLE POWER OF ATTORNEY FOR HEALTH CARE
(***Pursuant to Code of Federal Regulations, Title 38, Chapter 1, §17.32***)

4. **Document Purpose**. 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.

PART I: LIVING WILL

5. These are my (*print name*), _____ wishes for my future health care if there ever comes a time when I can't make these decisions for myself. I want any person I may have appointed as my Health Care Agent (HCA) in Part II (below), as well as my doctors, my family and others to be guided by the decisions I have made below.

A. Life-Sustaining Treatments (*initial if applies*)

_____ If I should have an incurable or irreversible condition that will cause my death, or I 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 (*initial if applies*)

_____ 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.

_____
_____
_____
_____
_____(*include additional pages, if necessary*)

PART II:
DURABLE POWER OF ATTORNEY
FOR HEALTH CARE (DPAHC)

6. I (*print name*), _____ write this document as a directive regarding my health care. I have personally put (or have caused to have put) my initials by each of the choices I want.

7. **Agent Appointment**. 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 of Agent: _____
   Address: _____
   Telephone: Home:_____ Work:_____
   Cell Phone or Pager: _____ E-mail: _____

8. **Alternate Appointment**. If the person above cannot or will not make decisions for me, I appoint this person:

   Name of Alternate #1:_____
   Address: _____
   Telephone: Home:_____ Work:_____
   Cell Phone or Pager: _____ E-mail: _____

9. **Agent Notification of Appointment**.

   _____ I have notified the individuals listed above of my decision.

   OR,

   _____ I have not appointed anyone to make health care decisions for me in this or any other documents.

PART III:
SIGNATURES

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

    Signature: _____

    Printed Name:_____ Date: _____

    Address: _____

    Telephone: Home: _____ Work: _____

11. **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.

1st Witness: _____
(Signature)

_____ _____
(Name Printed) (Date)

_____
(Residence Address)

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

2nd Witness: _____
(Signature)

_____ _____
(Name Printed) (Date)

_____
(Residence Address)

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 longer competent or able to give those instructions or make those choices verbally.

VA Form 10-0137 – Jul 1998 (RS) – Revised June 5, 2003.