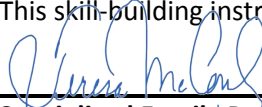



SPECIALIZED FAMILY CARE
Provider Training

Category:	Health
Title:	“Advance Directives for Health Care Decision-Making in WV”
Materials:	Document “Advance Directives for Health Care Decision-Making in West Virginia” from West Virginia Center for End-of-Life Care e-Directive Registry www.wvendoflife.org
Goal:	Specialized Family Care Provider has resources to complete Advance Directives
Credit Hours:	3 Hours
Date Developed:	October 2014, Updated January 2017
Developed by:	Donna McCune, SFC Program

This skill-building instruction has been approved for Specialized Family Care Provider training by:



Specialized Family Program Manager 2/17/2017
Date



Content Reviewed and updated by: Carol Brewster, FBCS 01-31-2017
Date

Training Objectives:

- Specialized Family Care Provider knows importance of preparing advance directives regarding his/her healthcare
- Specialized Family Care Provider has resources to complete a “Medical Power of Attorney” and or “Living Will” document
- Specialized Family Care Provider knows difference between Medical Power of Attorney and Living Will

Training Procedures:

- Specialized Family Care Provider initiated self-study
- Test completed by Specialized Family Care Provider
- Review of test responses by Family Based Care Specialist and Specialized Family Care Provider

I certify that I have completed all the materials associated with this training module. I feel that I have a basic understanding of the material completed.

Specialized Family Care Provider **Start Time** **End Time** **Date**

Reviewed by: _____
Family Based Care Specialist **Date**

This Program is funded by the WV Department of Health & Human Resources, Bureau for Children & Families and administered by the Center for Excellence in Disabilities, West Virginia University.

WVDHHR/CED/SFC/ADVANCE DIRECTIVES FOR HEALTH CARE DECISION MAKING IN WV/01-2017

WEST VIRGINIA CENTER FOR END-of-LIFE CARE

1-877-209-8086

www.wvendoflife.org

Advance Directives for Health Care Decision-Making in West Virginia *Frequently Asked Questions and Forms*

Six (6) FORMS INSIDE:

DO Not Resuscitate Sample (DNR) Form Page 6-7

Physician Orders for Scope of Treatment (POST) Form Page 8-9

Sign-up Form for WV e-Directive Registry on Page 16

Medical Power of Attorney Page 19-20

Living Will Page 23-24

Combined Living Will & Medical Power of Attorney Page 27-28-29

West Virginia Center for
End-of-Life Care
e-Directive Registry
FAX 844-616-1415

This booklet is based on the West Virginia Health Care Decisions Act passed by the West Virginia Legislature in March 2000 and amended in 2002 and 2007. The Center hopes that this booklet will be of assistance to West Virginians in understanding and completing advance directives. The Center's website at www.wvendoflife.org contains a copy of the West Virginia Health Care Decisions Act and additional forms that can be downloaded. The information in this booklet is not considered to be legal advice.

Revised March 2016

What are “Advance Directives for Healthcare Decision-Making?” Why are They Important?

As an adult, you have the right to make your own healthcare decisions. Your doctor and other healthcare providers must tell you about the nature of any proposed procedure or treatment, its probable benefits or effects, and any predictable discomfort, complications, or risks. You have the right to know about alternative treatments and their risks and benefits. You have the right to ask questions, and then you have the right to decide whether you want the treatment or not. Your right to accept medical or surgical treatment also includes the right to refuse it.

But what if you become incapable of making healthcare decisions for yourself because of injury or illness? Imagine that you are in a hospital, terminally ill with cancer, and are confused. Who will decide whether you should have CPR (cardiopulmonary resuscitation) if your heart should stop suddenly? Or what if you are 40 years old and are involved in a motor vehicle accident which leaves you permanently unconscious? Who will decide whether you are to be kept alive with tube feedings? Or what if you have Alzheimer’s disease and you develop a serious infection in a nursing home? Who will decide whether or not you will be hospitalized and treated with antibiotics?

“West Virginia Law Recognizes Two Types of Advance Directives . . . The Living Will and the Medical Power of Attorney.”

You can remain in charge of your health care, even after you can no longer make decisions for yourself, by creating a document called an “advance directive.”

West Virginia law recognizes **two types** of written advance directives for healthcare decision-making: the living will (Pg. 23) and the medical power of attorney. (Pg. 19) This booklet presents information about these directives and **includes the appropriate forms**. Both forms have a special section for you to write in specific comments about circumstances in which you would not want CPR, a feeding tube, dialysis, or treatment with a breathing machine. You should discuss these comments with your family and doctors so they can better understand what is important to you in receiving medical treatment. Should you wish to have both forms in one document, there is also a combined living will/medical power of attorney form in this booklet. (Pg. 27))

You can use these documents to let your family and doctor know your decisions for health care if you become unable to decide for yourself. You can appoint someone you know and

trust as your medical power of attorney representative to ensure that your choice or decision is honored.

Submit your Advance Directive Forms to the WV e-Directive Registry

The West Virginia Center for End-of-Life Care (WVCEOLC) through the WV Health Information Network (WVHIN) has established the WV e-Directive Registry. With the permission of patients, this electronic registry houses and makes available to treating health care providers West Virginians' advance directive forms, do not resuscitate (DNR) cards, (Pg. 6-7) and Physician Orders for Scope of Treatment (POST) forms. (Pg. 8-9) This is a password-protected – HIPAA compliant Registry that will make accurate, relevant information about patients' advance directives and medical orders available in a medical crisis. It will be accessible 24/7 to health care providers and ensure that patients' wishes will be respected throughout the continuum of health care settings.

Do not resuscitate (DNR), also known as **no code** or **allow natural death**, is a legal order written either in the hospital or on a legal form to withhold [cardiopulmonary resuscitation](#) (CPR) or [advanced cardiac life support](#) (ACLS), in respect of the wishes of a patient in case their [heart were to stop](#) or they were to [stop breathing](#). "No code" is a reference to the use of "code" as jargon for "calling in a [Code Blue](#)" to alert a hospital's resuscitation team. The DNR request is usually made by the patient or health care [power of attorney](#) and allows the medical teams taking care of them to respect their wishes. In the health care community, [allow natural death](#) (AND) is a term that is quickly gaining favor as it focuses on what is being done, not what is being avoided.

The [Center for Health Ethics and Law](#) is the distribution point for the **Physician Orders for Scope of Treatment (POST) form**. This document is designed to help health care professionals know and honor the treatment wishes of their patients. It puts the advance directive into action by translating the patient's treatment wishes into a medical order, centralizing information, facilitating record keeping, and ensuring transfer of appropriate information among health care professionals and across care settings.

The advance directive forms contained in this booklet contain an Opt-In box. If you would like to have your advance directive forms included in the Registry, you must **INITIAL** the box giving your permission to do so and **FAX** the forms to the Registry at 844-616-1415. If your advance directive form is older and does not contain the Opt-In box at the top, you can complete the WV e-Directive Registry Sign-Up form contained in this booklet (Copy **on Pg. 16**) and FAX it along with your older forms.

You may submit your advance directive forms do not resuscitate card, (DNR CARD) (**Copy included on page 6-7**) or Physician Orders for Scope of Treatment (POST) form (**Copy included on page 8 and 9**) to the WV e-Directive Registry by Faxing the forms or document to 844-616-1415. If you do not have a FAX machine available, you may upload your form directly to the Registry from the Center's website at www.wvendoflife.org, or you may mail a copy of your forms to the WV e-Directive Registry, 1195 Health Sciences North, Morgantown, WV 26506.

SAMPLE OF DNR (DO NOT RESUSCITATE) CARD

Date _____

VERIFICATION OF DO NOT RESUSCITATE ORDER

Dear MD/DO/APRN:

Please complete this card and with the permission of the patient, FAX the entire card to the WV e-Directive Registry, then detach at the perforation, give the bottom of the card to the patient, and keep the top in your records.

REGISTRY FAX: 844-616-1415

Last Name/First/Middle/Initial

Mailing Address: _____

City/State/Zip _____

Date of Birth (mm/dd/yyyy) _____

Last 4 SSN _____

Gender

___ M

___ F

Date: _____

DO NOT RESUSCITATE ORDER

As treating provider of _____
(patient name)

and a licensed MD/DO/APRN, I order that this person
SHALL NOT BE RESUSCITATED in the event of
cardiac or respiratory arrest. This order has been
discussed with _____

or his/her representative _____

or his/her surrogate decision maker _____

who has given consent as evidenced by his/her
signature below.

MD/DO/APRN Full Name (Printed) _____

MD/DO/APRN Signature _____

Address _____

Person/Surrogate Signature _____

Address _____

Date of Birth (mm/dd/yyyy) _____

Last 4 SSN

M

F

SAMPLE OF DNR (DO NOT RESUSCITATE) CARD REVERSE SIDE

**If you cancel this DNR Card,
CALL the WV e-Directive Registry at
877-209-8086**
so that it can be removed from the Registry.

**For more information or additional
cards, please contact:**

WV Center for End-of-Life Care
1195 Health Sciences North
P O Box 9022
Morgantown, WV 26506-9022
877-209-8086
www.wvendoflife.org

REGISTRY FAX: 844-616-1415

**If you cancel this DNR Card,
CALL the WV e-Directive Registry at
877-209-8086**
so that it can be removed from the Registry.

**For more information or additional
cards, please contact:**

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www.wvendoflife.org
REGISTRY FAX: 844-616-1415

HIPAA PERMITS DISCLOSURE OF POST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

West Virginia Physician Orders

for Scope of Treatment (POST)

By state law, these medical orders must be followed until changed. Any section not completed indicates full treatment for that section.

Last Name	First	Middle
-----------	-------	--------

Mailing Address

City/State/Zip

REVISE ADVANCE DIRECTIVES AS NEEDED FOR CONSISTENCY WITH POST ORDERS.

Date of Birth (mm/dd/yyyy)	Last 4 SSN	Gender
____/____/____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> M <input type="checkbox"/> F

A
Check One

CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing.

Attempt Resuscitation/CPR

Do Not Attempt Resuscitation/DNR

When not in cardiopulmonary arrest, follow orders in B, C, and D.

B
Check One

MEDICAL INTERVENTIONS: Person has pulse and is breathing.

Comfort Measures: Treat with dignity and respect. Keep clean, warm, and dry. Use medications by any route, positioning, wound care and other measures to relieve pain and suffering and promote comfort. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location. Treatment Plan: Maximize comfort through symptom management.

Limited Additional Interventions: Includes care described above. Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation or mechanical ventilation. Transfer to hospital if indicated. Include in intensive care unit. Treatment Plan: Hospitalize for routine medical treatment.

Full Interventions: Includes care above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Include in intensive care unit. Treatment Plan: Provide all medically indicated treatments including mechanical ventilation.

Additional Orders: _____

C
Check One Box Only in Each Column

MEDICALLY ADMINISTERED FLUIDS AND NUTRITION: Fluids and nutrition must be offered as tolerated.

No IV fluids (provide other measures to ensure comfort) No feeding tube

IV fluids for a trial period no longer than _____ Feeding tube long-term

Additional Orders: _____

D

Discussed with: Patient/Resident Health care surrogate MPOA representative Spouse Court-appointed guardian Parent of Minor Other: _____ (Specify)

Authorization: INITIAL BOX if you agree with the following statement: If I lose decision making capacity and my condition significantly deteriorates, I give permission to my MPOA representative/surrogate to make decisions and to complete a new form with my MD/DO/APRN in accordance with my expressed wishes for such a condition. If these wishes are unknown or not reasonably ascertainable, my best interests.

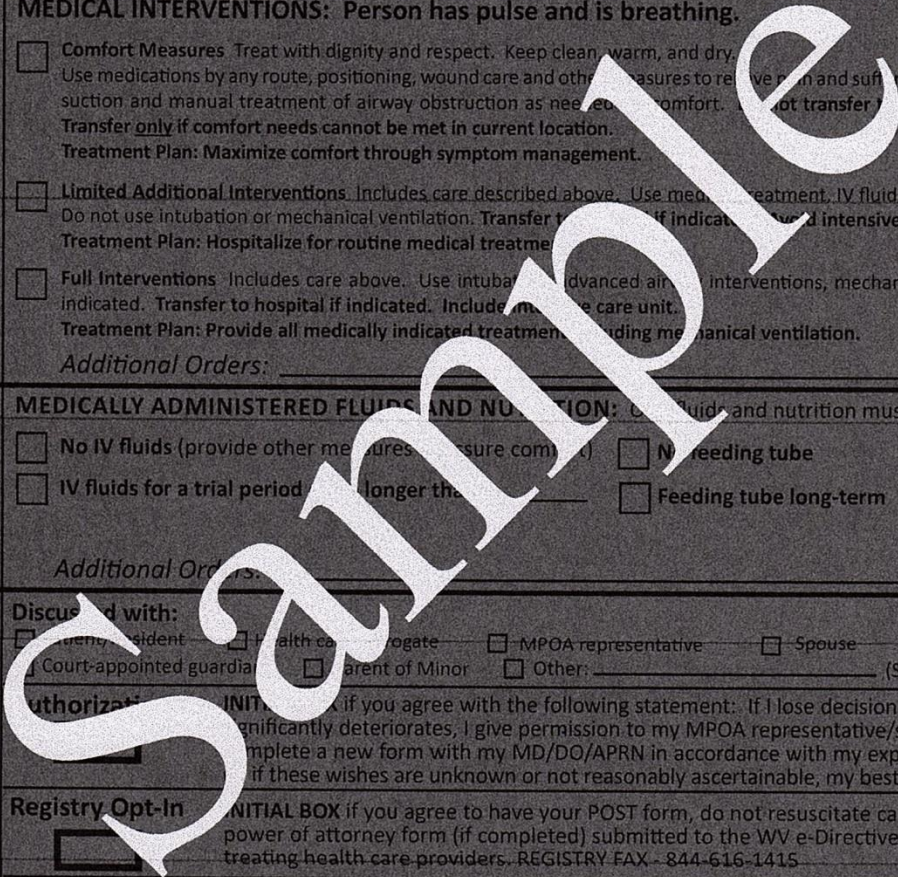
Registry Opt-In: INITIAL BOX if you agree to have your POST form, do not resuscitate card, living will and medical power of attorney form (if completed) submitted to the WV e-Directive Registry and released to treating health care providers. REGISTRY FAX - 844-616-1415

Signature of Patient/Resident, Parent of Minor, or Guardian/MPOA Representative/Surrogate (Mandatory)	Date
Signature of MD/DO/APRN	
MD/DO/APRN Name (Print Full Name)	MD/DO/APRN Phone Number
MD/DO/APRN Signature (Mandatory)	Date and Time

FORM SHALL ACCOMPANY PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

©Center for End-of-Life Care, Robert C. Byrd Health Sciences Center of West Virginia University, P.O. Box 9022, Morgantown, WV 26506, 1-877-209-8086

2016 e-Directive Registry FAX 844-616-1415



HIPAA PERMITS DISCLOSURE OF POST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

		Last Name	First	Middle
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E

Patient/Resident (Parent for Minor Child) Preferences as a Guide for this POST Form

Advance Directive (Living Will or MPOA)	<input type="checkbox"/> NO	<input type="checkbox"/> YES - Attach copy of documentation
Organ and Tissue Document of Gift	<input type="checkbox"/> NO	<input type="checkbox"/> YES - Attach copy of documentation
Court-appointed Guardian	<input type="checkbox"/> NO	<input type="checkbox"/> YES - Attach copy of documentation
Health Care Surrogate Selection	<input type="checkbox"/> NO	<input type="checkbox"/> YES - Attach copy of documentation

MPOA/Surrogate/Court-appointed Guardian/Parent of Minor Contact Information

Name	Address	Phone
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Person Preparing Form

Signature of Person Preparing Form	Preparer Name (Print)	Date Prepared
------------------------------------	-----------------------	---------------

F

Review of this POST Form

Date of Review	Reviewer	MD/DO/APRN Signature	Disposition of Review	Outcome of Review
				<input type="checkbox"/> No Change <input type="checkbox"/> FORM VOIDED, new form completed <input type="checkbox"/> FORM VOIDED, no new form
				<input type="checkbox"/> No Change <input type="checkbox"/> FORM VOIDED, new form completed <input type="checkbox"/> FORM VOIDED, no new form
				<input type="checkbox"/> No Change <input type="checkbox"/> FORM VOIDED, new form completed <input type="checkbox"/> FORM VOIDED, no new form
				<input type="checkbox"/> No Change <input type="checkbox"/> FORM VOIDED, new form completed <input type="checkbox"/> FORM VOIDED, no new form
				<input type="checkbox"/> No Change <input type="checkbox"/> FORM VOIDED, new form completed <input type="checkbox"/> FORM VOIDED, no new form
				<input type="checkbox"/> No Change <input type="checkbox"/> FORM VOIDED, new form completed <input type="checkbox"/> FORM VOIDED, no new form

Review of POST

This form should be reviewed if there is a substantial change in patient/resident health status or patient/resident treatment preferences. According to state law, this form may be reviewed if the patient/resident is transferred from one health care setting to another. If this form is to be voided, write the word "VOID" in large letters on the front of the form. After voiding the form, a new form may be completed. *If no new form is completed, note that full treatment and resuscitation may be provided.* FAX voided form and newly completed form to the Registry. Additional forms can be obtained by calling 877-209-8086 or ordered online from the WV Center for End-of-Life Care website at www.wvendoflife.org/Request-Information.

Instructions for Submission to the WV e-Directive Registry (if Opt-In Box is initialed)

FAX a copy of BOTH sides of the POST form to the e-Directive Registry at 844-616-1415. Copy form on your copy machine and adjust the lightness/darkness to contrast depending on your machine so that the form is readable prior to FAXing to the Registry. If you have questions about submission of this POST form or other advance directive documents to the Registry, call 877-209-8086. If you are using POST forms that were printed prior to 2010 and wish to submit them to the Registry, please complete a Sign-Up Form that contains the additional demographic information needed to identify the patient/resident in the Registry. The Sign-Up Form can be downloaded at www.wvendoflife.org/e-Directive-Registry.

FORM SHALL ACCOMPANY PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

©Center for End-of-Life Care, Robert C. Byrd Health Sciences Center of West Virginia University, P.O. Box 9022, Morgantown, WV 26506, 1-877-209-8086
2016

e-Directive Registry FAX 844-616-1415

Frequently Asked Questions about Advance Directives

1. What is a living will?

A living will is a legal document that tells your doctor how you want to be treated if you are terminally ill or permanently unconscious and cannot make decisions for yourself. A living will says that life-prolonging medical interventions that would serve solely to prolong your dying should not be used. A living will only applies if you are terminally ill or permanently unconscious AND too sick to make decisions for yourself.

2. What is a medical power of attorney?

A medical power of attorney is a legal document, a type of advance directive that allows you to name a person to make healthcare decisions for you if you are unable to make them for yourself.

3. How is the medical power of attorney different from the living will?

A living will only applies if you are terminally ill or permanently unconscious AND too sick to make decisions for yourself. A living will only tells your doctor what you do not want unless you write in other specific instructions. A living will is a written record of decisions that you have made yourself.

On the other hand, the medical power of attorney allows you to choose someone else to make healthcare decisions for you if you are too sick to make them for yourself. This person is called your medical power of attorney representative. Your representative can make any healthcare decision that you could make if you were able. A medical power of attorney allows you to give specific instructions to your representative about the type of care you would want to receive.

The medical power of attorney allows your representative to respond to medical situations that you might not have anticipated and to make decisions for you with knowledge of your values and wishes.

4. I am a young person in good health. Do I really need to create a formal advance directive?

Advance directives are for all adults, including mature minors and emancipated minors. We never know when an accident or serious illness will leave us incapable of making our own healthcare decisions.

5. What if I already have a living will? Do I need to create a medical power of attorney?

Most West Virginians create both a medical power of attorney and a living will. Since the medical power of attorney is a more flexible document and allows you to name someone to make decisions for you, it is advisable to create a medical power of attorney even if you have already signed a living will.

The representative you appoint as your medical power of attorney representative can help see that the preferences expressed in your living will are carried out. Some people, however, do not have someone whom they trust or who knows their values and preferences. These people should consider creating a living will.

If you choose to sign both documents, you should see that they are stored in the same place to help assure that your representative will know to respect all of your wishes. Alternatively, you may complete a combined living will and medical power of attorney document.

5. Should I complete a new living will or medical power of attorney if I completed one before June 11, 2000?

On June 11, 2000, a new law went into effect that made several changes to the living will and medical power of attorney forms. Most importantly, the new law requires only one physician to decide whether you are able to make your own healthcare decisions. Forms completed prior to the new law require two physicians to make this determination. The new forms also are written in clearer, easy to understand language. If you want to take advantage of these changes, you should complete a new living will and medical power of attorney.

6. Can I combine my living will and medical power of attorney in one form?

Yes. If you do not want CPR, feeding tubes, breathing machines, or other life-prolonging interventions if you become terminally ill or permanently unconscious, then you can use one document that combines both the living will and the medical power of attorney forms.

7. Can I still make my own healthcare decisions once I have created an advance directive?

Yes. Your living will does not become effective until you are terminally ill or permanently unconscious AND too sick to make decisions for yourself. As long as you can do this, you have the right to make your own decisions. Your medical power of attorney does not become effective until you are not able to clearly say your own wishes.

9. If I decide to create a medical power of attorney, how should I choose my representative?

Choose someone who knows your values and wishes, and whom you trust to make decisions for you. Do the same for a successor representative. Ask both to be sure they understand and agree to be your representative.

You may, but do not have to, choose a family member to be your representative. Regardless of your choice, your representative should be someone who will be available if needed and who will decide matters the way you would decide.

Name only one person each as your representative and your successor representative. Do not choose your doctor, or another person who is likely to be your future healthcare provider, as your representative or successor representative.

10. What instructions should I give my representatives concerning my health care?

You may give very general instructions and preferences, or be quite specific. It would be helpful to your representatives to have directions from you about medical conditions in which you would NOT want life prolonging intervention, particularly medically administered food and water (tube feedings), cardiopulmonary resuscitation (CPR), and the use of machines to help you breathe. You should also tell your representative if you want to be an organ and tissue donor.

Many people choose to write their representatives a letter stating their personal values and wishes, their feelings about life and death, and any specific instructions, and to attach a copy of this letter to their medical power of attorney.

Talk with your representatives about your choices and personal values and beliefs. Make sure they know what is important to you. This information will help them make the decisions that you would make if you were able.

11. Can any person create an advance directive?

Yes. Any adult (including a mature or emancipated minor) who has the capacity to make decisions for him or herself can create an advance directive.

12. Do I need a lawyer to create an advance directive?

No. An advance directive can be created without the assistance of a lawyer.

13. Who should witness my signature on my advance directive?

Your witnesses must be at least 18 years of age and not related to you by blood or marriage. Choose persons who will not inherit any of your property. Do not choose the person you named as your representative or your successor representative or your doctor as your witness.

14. How can I find a Notary Public to complete my medical power of attorney form?

Businesses such as banks, insurance agents, government offices, hospitals, doctors' offices, and automobile associations have or can direct you to a notary public.

15. What should I do with my advance directive after I sign it?

After your advance directive is signed, witnessed and notarized, keep the original document in a safe location where it can be easily found. A photo copy of your advance directive is legally valid. So that your advance directive can be found in a medical emergency, you are encouraged to submit your form to the WV e-Directive Registry by Faxing it to 844-616-1415, mailing a copy to the WV e-Directive Registry, 1195 Health Sciences North, Morgantown, WV 26506, or scanning and submitting it online at <http://www.wvendoflife.org>.

16. What if my doctor or my family does not agree with my treatment choices or healthcare decisions?

You can prevent this from happening by talking with your family and healthcare providers about your decisions and personal values and beliefs. If others understand your choices and the reasons for them, there is less of a chance that they will challenge them later.

If you have made your wishes known in an advance directive and a disagreement does occur, your doctor and your representative must respect your wishes. You have a right to refuse or consent to health care. If your doctor cannot comply with your wishes, he or she must transfer your care to another doctor.

The consent or refusal of your medical power of attorney representative is as meaningful and valid as your own. The wishes of other family members will not override your own clearly expressed choices or those made by your representative on your behalf.

17. Do I have to sign an advance directive to receive healthcare treatment?

No. A doctor or other healthcare provider cannot require you to complete an advance directive as a condition for you to receive services.

18. Will another state honor my advance directive?

Laws differ somewhat from state to state, but in general, a patient's expressed wishes will be honored.

19. What if I change my mind about who I want to be my representative or about the kind of treatment I want?

You should review your advance directive periodically to make sure it still reflects your wishes. The best way to change your advance directive is to create a new one. The new document will automatically cancel the old one. Be sure to notify all people who have copies of your advance directive that you completed a new one. Collect and destroy all copies of the old version. Send the new version to the e-Directive Registry so that your current one is available to treating health care providers.

Remember to submit your new advance directive to the WV e-Directive Registry by Faxing it to 844-616-1415 or mailing a copy to the WV e-Directive Registry, 1195 Health Sciences North, Morgantown, WV 26506.

20. How can I be sure that the wishes expressed in my advance directive will be followed?

Be sure your doctor has a current copy. Bring a copy with you if you are admitted to a healthcare facility. Tell people where you keep your advance directive. FAX a copy of your advance directive to the WV e-Directive Registry at 844-616-1415, so that your wishes will be known in a medical emergency.

21. What Special Directives or Limitations are inconsistent with the purpose of the Living Will? –

Requests for CPR or breathing machines are inconsistent with the purpose of the living will and will be held to be invalid. West Virginia Code §16-30-4(g)

22. Can I write my wishes for funeral arrangements on my advance directive?

Yes, you can give the person you name as your medical power of attorney representative the authority to make decisions for you about funeral arrangements or cremation. The way to do so is to write instructions in the Special Directives or Limitations on this section of the medical power of attorney form or the combined medical power of attorney-living will form. To grant authority to your medical power of attorney representative, include a sentence as follows: “I authorize my representative to make decisions regarding my funeral arrangements or cremation.”

23. How can I get more copies of the advance directives forms and this booklet?

You may call the **West Virginia Center for End-of-Life Care** toll-free at **1-877-209-8086**. If you have Internet access, go to www.wvendoflife.org and click on Public/Forms. You can print off forms from the website. You may also photo copy the forms in this booklet.

**West Virginia Center for
End-of-Life Care
e-Directive Registry**

**West Virginia e-Directive Registry Sign-Up Form
with Additional Required Demographic Information**

In October 2010, West Virginia advance directive and medical order forms (DNR and POST) were changed to include more demographic information. West Virginia advance directives (Living Wills and Medical Powers of Attorney) and physician orders (DNR cards and POST forms) that do not include demographic information at the top of the form must have additional identifying information submitted in order to be added to the e-Directive Registry. With the patient's permission (or the medical power of attorney representative/surrogate's permission if the patient lacks capacity), fill in the information below and FAX or mail this form with a copy of **BOTH** sides of the advance directive and/or DNR card and/or POST form.

OPT-IN Initial in the box to the left if you give permission as the person or as the guardian, medical power of attorney representative, or surrogate decision maker of the person to have the attached or previously submitted Living Will, Medical Power of Attorney, POST form, and/or DNR card (if completed) included in the WV Directive registry and released to treating health care providers.

Please provide the following required information:

(Last Name/First/Middle Initial)

(Date of Birth)

(Address)

(City, State, Zip Code)

Gender (check one): (Male) (Female)

Last 4 numbers of your Social Security number: ____ ____ ____ ____

Updating Demographic Information:

Please initial box below if only updating demographic information. Please fax or mail a completed copy of this revised form.

Demographic updates for previously submitted advance directive forms to e-Directive Registry.

WV e-Directive Registry
1195 Health Sciences North
P O Box 9022
Morgantown, WV 26506-9022
Phone: 877-209-8086
FAX: 844-616-1415

**West Virginia Center for
End-of-Life Care**

Frequently Asked Questions about the Medical Power of Attorney

- ***What is a medical power of attorney?***

A medical power of attorney is a legal document, a type of advance directive, that allows you to name a person to make healthcare decisions for you if you are unable to make them for yourself.

- ***What if I already have a living will? Do I need to create a medical power of attorney?***

Most West Virginians complete both a medical power of attorney and a living will. Since the medical power of attorney is a more flexible document and allows you to name someone to make decisions for you, it is advisable to create a medical power of attorney even if you have already signed a living will or decide not to do a living will.

- ***Can I still make my own healthcare decisions once I have created a medical power of attorney?***

Yes. Your medical power of attorney does not become effective until you are not able to clearly say your own wishes.

- ***If I decide to create a medical power of attorney, how should I choose my representative?***

Choose someone who knows your values and wishes, and whom you trust to make decisions for you. Do the same for a successor representative. Ask both to be sure they understand and agree to be your representative.

- ***What if I change my mind about who I want to be my representative or about the kind of treatment I want?***

You should review your medical power of attorney periodically to make sure it still reflects your wishes. The best way to change your medical power of attorney is to create a new one. The new document will automatically cancel the old one. Be sure to notify all people who have copies of your medical power of attorney that you completed a new one. Collect and destroy all copies of the old version. Send the new version to the e-Directive Registry so that your current one is available to treating health care providers.

- ***Do I need a lawyer to create a medical power of attorney?***

No. A medical power of attorney can be completed without the assistance of a lawyer.

- ***Will another state honor my medical power of attorney?***

Laws differ somewhat from state to state, but in general, a patient's expressed wishes will be honored

- ***What should I do with my medical power of attorney after I sign it?***

After your medical power of attorney is signed, witnessed and notarized, keep the original document in a safe location where it can be easily found. A photo copy of your medical power of attorney is legally valid. You are encouraged to send a copy of your medical power of attorney to the West Virginia e-Directive Registry. See instructions below.

A complete listing of all Frequently Asked Questions relating to the Medical Power of Attorney can be found by clicking on the FAQs link on this page.

So that your medical power of attorney will can be found in a medical emergency, you are encouraged to submit your form to the WV e-Directive Registry by FAXing it to 844-616-1415, mailing a copy to the WV e-Directive Registry, 1195 Health Sciences North, Morgantown, WV 26506, or scanning and submitting it online at <http://www.wvendoflife.org>. The medical power of attorney on this site contains an Opt-In box. If you would like to have your medical power of attorney included in the Registry, you must INITIAL the box giving your permission.

Phone 877-209-8086 FAX: 844-616-1415 website: www.wvendoflife.org

Opt in Initial box if you agree to have This advance directive submitted to the WV e-Directive Registry, and released to treating health care providers. Complete information to RIGHT.

REGISTRY FAX: 844-616-1415

Last Name/First/Middle _____
Address _____
City/State/Zip _____
Date of Birth (mm/dd/yyyy) ____/____/____
Last 4 SSN ____-____-____ Gender M____ F____

STATE OF WEST VIRGINIA MEDICAL POWER OF ATTORNEY

The Person I Want to Make Health Care Decisions
For Me When I Can't Make Them for Myself

Dated: _____, 20____

I, _____, hereby
(Insert your name and address)

appoint as my representative to act on my behalf to give, withhold or withdraw informed consent to health care decisions in the event that I am not able to do so myself.

The person I choose as my representative is:

(Insert the name, address, area code and telephone number of the person you wish to designate as your representative)

The person I choose as my successor representative is:

If my representative is unable, unwilling or disqualified to serve, then I appoint

(Insert the name, address, area code and telephone number of the person you wish to designate as your successor representative)

This appointment shall extend to, but not be limited to, health care decisions relating to medical treatment, surgical treatment, nursing care, medication, hospitalization, care and treatment in a nursing home or other facility, and home health care. The representative appointed by this document is specifically authorized to be granted access to my medical records and other health information and to act on my behalf to consent to, refuse or withdraw any and all medical treatment or diagnostic procedures, or autopsy if my representative determines that I, if able to do so, would consent to, refuse or withdraw such treatment or procedures. Such authority shall include, but not be limited to, decisions regarding the withholding or withdrawal of life-prolonging interventions.

I appoint this representative because I believe this person understands my wishes and values and will act to carry into effect the health care decisions that I would make if I were able to do so, and because I also believe that this person will act in my best interest when my wishes are unknown. It is my intent that my family, my physician and all legal authorities be bound by the decisions that are made by the representative appointed by this document, and it is my intent that these decisions should not be the subject of review by any health care provider or administrative or judicial agency.

Principal Name (person for whom form is being completed): _____

It is my intent that this document be legally binding and effective and that this document be taken as a formal statement of my desire concerning the method by which any health care decision should be made on my behalf during any period when I am unable to make such decisions.

In exercising the authority under this medical power of attorney, my representative shall act consistently with my special directives or limitations as stated below.

I am giving the following SPECIAL DIRECTIVES OR LIMITATIONS ON THIS POWER: (Comments about tube feedings, breathing machines, cardiopulmonary resuscitation, dialysis, funeral arrangements, autopsy, and organ donation may be placed here. My failure to provide special directives or limitations does not mean that I want or refuse certain treatments.)

THIS MEDICAL POWER OF ATTORNEY SHALL BECOME EFFECTIVE ONLY UPON MY INCAPACITY TO GIVE, WITHHOLD OR WITHDRAW INFORMED CONSENT TO MY OWN MEDICAL CARE.

Signature of Principal DATE: _____

I did not sign the principal's signature above. I am at least eighteen years of age and am not related to the principal by blood or marriage. I am not entitled to any portion of the estate of the principal or to the best of my knowledge under any will of the principal or codicil thereto, or legally responsible for the costs of the principal's medical or other care. I am not the principal's attending physician, nor am I the representative or successor representative of the principal.

Witness: _____ DATE: _____

Witness: _____ DATE: _____

STATE OF _____

COUNTY OF _____

I, _____, a Notary Public of said County, do certify that _____, as principal, and _____ and _____, as witnesses, whose names are signed to the writing above bearing date on the _____ day of _____, 20____, have this day acknowledged the same before me.

Given under my hand this _____ day of _____, 20_____.

My commission expires: _____

Notary Public

**West Virginia Center for
End-of-Life Care**

Frequently Asked Questions about the Living Will

- ***What is a living will?***

A living will is a legal document that tells your doctor how you want to be treated if you are terminally ill or permanently unconscious and cannot make decisions for yourself. A living will says that life-prolonging medical interventions that would serve solely to prolong your dying should not be used. A living will only applies if you are terminally ill or permanently unconscious AND too sick to make decisions for yourself.

- ***Can I still make my own healthcare decisions once I have created a living will?***

Yes. Your living will does not become effective until you are terminally ill or permanently unconscious AND too sick to make decisions for yourself. As long as you can do this, you have the right to make your own decisions.

- ***Can any person create a living will?***

Yes. Any adult (including a mature or emancipated minor) who has the ability to make decisions for him or herself can complete a living will.

- ***Do I need a lawyer to create a living will?***

No. A living will can be completed without the help of a lawyer.

- ***Will another state honor my living will?***

Laws differ somewhat from state to state, but in general, a patient's expressed wishes will be honored.

- *What should I do with my living will after I sign it?*

After your living will is signed, witnessed and notarized, keep the original document in a safe location where it can be easily found. A photo copy of your advance directive is legally valid.

A complete listing of all Frequently Asked Questions relating to the Living Will can be found by clicking on the FAQs link on this page.

So that your living will can be found in a medical emergency, you are encouraged to submit your form to the WV e-Directive Registry by FAXing it to 844-616-1415, mailing a copy to the WV e-Directive Registry, 1195 Health Sciences North, Morgantown, WV 26506, or scanning and submitting it online at <http://www.wvendoflife.org>. The living will on this site contains an Opt-In box. If you would like to have your living will included in the Registry, you must INITIAL the box giving your permission.

Phone 877-209-8086 FAX: 844-616-1415 website: www.wvendoflife.org

Opt In INITIAL box if you agree to have this advance directive submitted to the WV e-Directive Registry, and released to treating health care providers. Complete information to RIGHT. REGISTRY FAX: 844-616-1415

Last Name/First/Middle _____
Address _____
City/State/Zip _____
Date of Birth (mm/dd/yyyy) _____
Last 4 SSN ---- ---- ---- Gender M ___ F

**STATE OF WEST VIRGINIA
LIVING WILL**

**The Kind of Medical Treatment I Want and Don't Want
If I Have a Terminal Condition or Am In a Persistent Vegetative State**

Living will made this _____ day of _____ (month, year).
I, _____, being of sound mind, willfully and voluntarily declare that I want my wishes to be respected if I am very sick and not able to communicate my wishes for myself. In the absence of my ability to give directions regarding the use of life-prolonging medical intervention, it is my desire that my dying shall not be prolonged under the following circumstances:

If I am very sick and not able to communicate my wishes for myself and I am certified by one physician who has personally examined me, to have a terminal condition or to be in a persistent vegetative state (I am unconscious and am neither aware of my environment nor able to interact with others,) I direct that life-prolonging medical intervention that would serve solely to prolong the dying process or maintain me in a persistent vegetative state be withheld or withdrawn. I want to be allowed to die naturally and only be given medications or other medical procedures necessary to keep me comfortable. I want to receive as much medication as is necessary to alleviate my pain.

I give the following SPECIAL DIRECTIVES OR LIMITATIONS: (Comments about tube feedings, breathing machines, cardiopulmonary resuscitation, dialysis, and mental health treatment may be placed here. My failure to provide special directives or limitations does not mean that I want or refuse certain treatments.)

It is my intention that this living will be honored as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences resulting from such refusal.

I understand the full import of this living will.

Signed _____ Date _____

Address _____

Principal Name (person for whom form is being completed): _____

I did not sign the principal's signature above for or at the direction of the principal. I am at least eighteen years of age and am not related to the principal by blood or marriage, entitled to any portion of the estate of the principal to the best of my knowledge under any will of principal or codicil thereto, or directly financially responsible for principal's medical care. I am not the principal's attending physician or the principal's medical power of attorney representative or successor medical power of attorney representative under a medical power of attorney.

Witness _____ DATE _____

Witness _____ DATE _____

STATE OF _____

COUNTY OF _____

I, _____, a Notary Public of said County, do certify that _____, as principal, and _____, and _____, as witnesses, whose names are signed to the writing above bearing date on the day of, 20____, have this day acknowledged the same before me.

Given under my hand this _____ day of _____, 20____.

My commission expires: _____

Signature of Notary Public

Frequently Asked Questions about the Combined Living Will/Medical Power of Attorney

- ***Can I combine my living will and medical power of attorney in one form?***

Yes. If you do not want CPR, feeding tubes, breathing machines, or other life-prolonging interventions if you become terminally ill or permanently unconscious, then you can use one document that combines both the living will and the medical power of attorney forms.

- ***Can I still make my own healthcare decisions once I have completed a combined form?***

Yes. Your combined form will does not take effect until you cannot make decisions for yourself. The living will portion of the combined form takes effect when you are terminally ill or permanently unconscious. As long as you can make your own decisions, the form is NOT in effect.

- ***Can any person creates a combined form?***

Yes. Any adult (including a mature or emancipated minor) who has the ability to make decisions for him or herself can complete a combined form.

- ***Do I need a lawyer to create a combined form?***

No. A combined form can be completed without the help of a lawyer.

- ***Will another state honor my combined form?***

Laws differ somewhat from state to state, but in general, a patient's expressed wishes will be honored.

- ***What should I do with my combined form after I sign it?***

After your form is signed, witnessed and notarized, keep the original document in a safe location where it can be easily found. A photo copy of your combined form is legally valid. You are encouraged to send a copy of your-combined form to the West Virginia e-Directive Registry. See instructions below.

A complete listing of all Frequently Asked Questions relating to the Combined Living Will/Medical Power of Attorney can be found by clicking on the FAQs link on this page.

So that your combined form can be found in a medical emergency, you are encouraged to submit your form to the WV e-Directive Registry by FAXing it to 844-616-1415, mailing a copy to the WV e-Directive Registry, 1195 Health Sciences North, Morgantown, WV 26506, or scanning and submitting it online at <http://www.wvendoflife.org>. The combined living/medical power of attorney on this site contains an Opt-Inbox. If you would like to have your combined form included in the Registry, you must INITIAL the box giving your permission.

Phone 877-209-8086 FAX: 844-616-1415 website: www.wvendoflife.org

OPT In INITIAL box if you agree to have this advance directive submitted to the WV e-Directive Registry, and released to treating health care providers.
REGISTRY FAX: 304-844-616-1415

Last Name/First/Middle _____
Address _____
City/State/Zip _____
Last 4 SSN ---- - - - - Gender M ___ F ___

STATE OF WEST VIRGINIA
COMBINED
MEDICAL POWER OF ATTORNEY
AND LIVING WILL

The Person I Want to Make Health Care Decisions
For Me When I Can't Make Them for Myself
And
The Kind of Medical Treatment I Want and Don't Want
If I Have a Terminal Condition or Am In a Persistent Vegetative State

Dated: _____, 20____

I, _____, hereby
(Insert your name and address)

appoint as my representative to act on my behalf to give, withhold or withdraw informed consent to health care decisions in the event that I am not able to do so myself.

The person I choose as my representative is:

(Insert the name, address, area code and telephone number of the person you wish to designate as your representative)

The person I choose as my successor representative is:

If my representative is unable, unwilling or disqualified to serve, then I appoint

(Insert the name, address, area code and telephone number of the person you wish to designate as your successor representative)

Principal Name (person for whom form is being completed): _____

This appointment shall extend to, but not be limited to, health care decisions relating to medical treatment, surgical treatment, nursing care, medication, hospitalization, care and treatment in a nursing home or other facility, and home health care. The representative appointed by this document is specifically authorized to be granted access to my medical records and other health information and to act on my behalf to consent to, refuse or withdraw any and all medical treatment or diagnostic procedures, or autopsy if my representative determines that I, if able to do so, would consent to, refuse or withdraw such treatment or procedures. Such authority shall include, but not be limited to, decisions regarding the withholding or withdrawal of life-prolonging interventions.

I appoint this representative because I believe this person understands my wishes and values and will act to carry into effect the health care decisions that I would make if I were able to do so, and because I also believe that this person will act in my best interest when my wishes are unknown. It is my intent that my family, my physician and all legal authorities be bound by the decisions that are made by the representative appointed by this document, and it is my intent that these decisions should not be the subject of review by any health care provider or administrative or judicial agency.

It is my intent that this document be legally binding and effective and that this document be taken as a formal statement of my desire concerning the method by which any health care decisions should be made on my behalf during any period when I am unable to make such decisions.

In exercising the authority under this medical power of attorney, my representative shall act consistently with my special directives or limitations as stated below.

I am giving the following **SPECIAL DIRECTIVES OR LIMITATIONS ON THIS POWER:** (Comments about tube feedings, breathing machines, cardiopulmonary resuscitation, dialysis, mental health treatment, funeral arrangements, autopsy, and organ donation may be placed here. My failure to provide special directives or limitations does not mean that I want or refuse certain treatments).

1. If I am very sick and not able to communicate my wishes for myself and I am certified by one physician who has personally examined me, to have a terminal condition or to be in a persistent vegetative state (I am unconscious and am neither aware of my environment nor able to interact with others,) I direct that life-prolonging medical intervention that would serve solely to prolong the dying process or maintain me in a persistent vegetative state be withheld or withdrawn. I want to be allowed to die naturally and only be given medications or other medical procedures necessary to keep me comfortable. I want to receive as much medication as is necessary to alleviate my pain.

2. Other directives: _____

THIS MEDICAL POWER OF ATTORNEY SHALL BECOME EFFECTIVE ONLY UPON MY INCAPACITY TO GIVE, WITHHOLD OR WITHDRAW INFORMED CONSENT TO MY OWN MEDICAL CARE.

Signature of the Principal DATE _____

I did not sign the principal's signature above. I am at least eighteen years of age and am not related to the principal by blood or marriage. I am not entitled to any portion of the estate of the principal or to the best of my knowledge under any will of the principal or codicil thereto, or legally responsible for the costs of the principal's medical or other care. I am not the principal's attending physician, nor am I the representative or successor representative of the principal.

Witness _____ DATE _____

Witness _____ DATE _____

STATE OF _____

COUNTY OF _____

I, _____, a Notary Public of said County, do certify that _____, as principal, and _____ and _____, as witnesses, whose names are signed to the writing above bearing date on the _____ day of _____, 20____, have this day acknowledged the same before me.

Given under my hand this _____ day of _____, 20_____.

My commission expires: _____

Signature of Notary Public