

# DAVIS & MCDANIEL VETERANS CARE CENTER

## MEDICAL REVIEW SHEET



All medical forms must be completed no more than 30 days prior admission. **Davis & McDaniel Veterans Care Center**  
To aid in the placement of our future residents, we will need the following documents. Please contact the DMVCC Admissions Team for guidance on how to obtain or complete these documents.

### ADMISSIONS FROM HOSPITAL/SKILLED NURSING FACILITY (SNF)

- Current Physician orders
- Current Medication Administration Records
- Current Nurse's notes
- Chest x-ray completed within the past 30 days
- Recent labs
- Current Physician notes and rehab progress notes
- History and physical (current)
- Completed DMAS-96, DMAS-95 and Unconditionally Available Income (UAI) (1204 from Richmond VAMC)
- Psych eval/progress notes
- Operative reports
- Consultations
- Do Not Resuscitate (DNR) (if applicable)
- Discharge Summary/Physician's Discharge Orders

### ADMISSIONS FROM HOME

- Current Physician Referral
- Chest x-ray completed within the past 30 days
- Office visits progress notes if available (current)
- Completed DMAS-96, DMAS-95 and UAI

### ALL ADMISSIONS REQUIRE COPIES OF THE FOLLOWING DOCUMENTS:

- DD-214
- Medicare card
- Medicare Part D insurance card
- Secondary insurance card (if applicable)
- Medicaid card (if applicable)
- Power of Attorney or Guardian documentation
- Living Will

### IMPORTANT NOTE:

Please do not bring a powered wheelchair or powered scooter at admission. Before a resident can use those in the center, he/she must be screened by the Therapy Department in order to make sure they can operate it safely.

**DAVIS & MCDANIEL VETERANS CARE CENTER**  
**AUTHORIZATION FOR THE RELEASE OF**  
**HEALTH INFORMATION RECORDS**



Virginia Department of Veterans Services  
**Davis & McDaniel Veterans Care Center**

I hereby authorize DAVIS & MCDANIEL VETERANS CARE CENTER (Provider's Name) to disclose my individual identifiable health information as described below.

| Patient's Name  | Social Security Number  | Date of Birth |
|---|---|---------------|
| Name and address of person(s) or organization(s) requesting the records, if different from the patient: | Name and address of person(s) or organization to receive the records: |               |
|   |   |               |
|   |   |               |
|   |   |               |

I will review the records at the provider's location.

I am requesting that the provider copy the records and send the records to the above address.

I wish to have the following records copied, and I will pick them up at the provider's location.

**INFORMATION REQUESTED (please initial)**

I am requesting the following records from the patient's medical records that were created between \_\_\_/\_\_\_/\_\_\_ and \_\_\_/\_\_\_/\_\_\_:

- |                           |                              |                   |
|---------------------------|------------------------------|-------------------|
| ___ Dietary Notes         | ___ Activity Notes           | ___ Nursing Notes |
| ___ Physician Notes       | ___ Physician Progress Notes | ___ Care Plans    |
| ___ Discharge Summary     | ___ X-ray Reports            | ___ Lab Results   |
| ___ Social Services Notes | ___ Therapy Notes            |                   |
| ___ Other: _____          |                              |                   |
| ___ Other: _____          |                              |                   |

Purpose in which records will be used: \_\_\_\_\_

**DAVIS & MCDANIEL VETERANS CARE CENTER**  
**AUTHORIZATION FOR THE RELEASE OF**  
**HEALTH INFORMATION RECORDS (CONT.)**



Virginia Department of Veterans Services  
**Davis & McDaniel Veterans Care Center**

- \_\_\_\_\_ I am the patient noted above.
- \_\_\_\_\_ I am the patient's legal decision maker under state law and I am entitled to receive the medical records under state law.
- \_\_\_\_\_ I am the patient attorney-in-fact, and I have attached to this authorization a valid Power of Attorney or Durable Power of Attorney for Health Care (DPAHC) that grants me the power to request the patient's medical records.
- \_\_\_\_\_ I am the patient's legal guardian, and I have attached to this authorization a valid appointment of guardianship from a probate court.
- \_\_\_\_\_ If the patient is deceased: I am the executor/administrator of the patient's estate, and I have attached to this authorization a valid appointment as such from a probate court.
- \_\_\_\_\_ The patient has executed a legally binding instrument granting me the authority to obtain his/her medical records, and I have attached a copy of this instrument to this authorization.
- \_\_\_\_\_ The patient's legally authorized representative has executed a legally binding instrument granting me the authority to obtain the patient's medical records. I have attached a copy of the instrument granting me such authority, as well as evidence that the person who executed that instrument had the legal authority to do so (example: a power of attorney or probate court order).

**UNDERSTANDINGS AND AGREEMENTS OF REQUESTOR**

1. This authorization is voluntary.
2. This authorization will expire two (2) months from the date of my signature below.
3. I understand that I may revoke this authorization at any time by notifying the provider in writing, but if I do, it will have no effect on any actions taken prior to receiving the revocation.
4. I agree to waive all claims against the providers for the release of the requested information.
5. I understand that once the information described herein is disclosed, it may no longer be subject to the privacy protection afforded by the provider if the recipient of the information is not a health plan, health care provider, health care clearing house, or a business associate that has the contract with the provider.
6. The provider may not place conditions on treatment, payment, enrollment or eligibility for benefits on whether I sign an authorization when the prohibition on conditioning of authorizations applies.
7. I understand that I must provide the provider with at least twenty-four (24) hours notice before coming to the provider.
8. I understand that after I have reviewed the records, I must provide the provider with two (2) working days advance notice of any copies of the record that I would like to pick up at the provider's location.
9. I understand that if I requested that record to be copied and sent to me that the provider would make a good faith effort to send those records to me in a reasonable amount of time.
10. I understand that if I wish to have copies of records made, then the provider will access a fee for copying the records.
11. The provider will notify me of the total amount due for copying and shipping of the requested records. I agree that the provider will only send me the requested information once it has received payment in full for those costs.

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**Signature of Requestor**

**Print Name**

**Date**

# DAVIS & MCDANIEL VETERANS CARE CENTER

## APPLICATION FOR ADMISSION



Virginia Department of Veterans Services

Davis & McDaniel Veterans Care Center

### RESIDENT INFORMATION

|  |   |  |                                 |
|--|---|--|---------------------------------|
| FIRST NAME   | MIDDLE NAME   | LAST NAME  | SUFFIX                          |
| SSN:   | DOB<br>MONTH / DAY / YEAR   | PREFERRED NAME   |                                 |
| RELIGIOUS PREFERENCE   |   | DO YOU SMOKE OR VAPE? <input type="checkbox"/> YES <input type="checkbox"/> NO |                                 |
| MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Never Married |   |  |                                 |
| DESIRED ARRIVAL DATE<br>MONTH / DAY / YEAR   | EXPECTED LEVEL OF CARE:<br><input type="checkbox"/> NURSING HOME <input type="checkbox"/> DEMENTIA CARE |  | APPLICANT COMING TO DMVCC FROM: |
| MOTHER'S MAIDEN NAME   | VIRGINIA RESIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO                             | HOW LONG?  |                                 |

### SERVICE INFORMATION

|   |  |   |        |
|---|--|---|--------|
| MILITARY SERVICE: <input type="checkbox"/> Coast Guard <input type="checkbox"/> Army <input type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Air Force <input type="checkbox"/> Reserves |  |   |        |
| SERVICE NUMBER:   |  | TYPE OF DISCHARGE                                 |        |
| DATE ENTERED INTO SERVICE<br>MONTH / DAY / YEAR   |  | DATE SEPARATED FROM SERVICE<br>MONTH / DAY / YEAR |        |
| DO YOU HAVE A COPY OF YOUR DD-214? <input type="checkbox"/> YES <input type="checkbox"/> NO   |  |   |        |
| HAVE YOU RECEIVED TREATMENT AT A VA HOSPITAL? <input type="checkbox"/> YES <input type="checkbox"/> NO  |  |   | WHERE: |
| SERVICE CONNECTED DISABILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO  |  | IF SO, WHAT PERCENT?                              |        |

### RESPONSIBLE PARTY AND FIRST EMERGENCY CONTACT

*(Must be someone OTHER than Resident)*

|              |  |
|--------------|--|
| NAME         | COMPLETE MAILING ADDRESS:  |
| RELATIONSHIP | EMAIL ADDRESS:   |
| <b>PHONE</b> | <input type="checkbox"/> NEXT OF KIN<br><input type="checkbox"/> POWER OF ATTORNEY<br><input type="checkbox"/> COURT APPOINTED GUARDIAN<br><input type="checkbox"/> VA FIDUCIARY |
| HOME         |  |
| CELL         |  |
| OFFICE       |  |

### SECONDARY EMERGENCY CONTACT

|              |  |
|--------------|--|
| NAME         | COMPLETE MAILING ADDRESS:  |
| RELATIONSHIP | EMAIL ADDRESS:   |
| <b>PHONE</b> | <input type="checkbox"/> NEXT OF KIN<br><input type="checkbox"/> POWER OF ATTORNEY<br><input type="checkbox"/> COURT APPOINTED GUARDIAN<br><input type="checkbox"/> VA FIDUCIARY |
| HOME         |  |
| CELL         |  |
| OFFICE       |  |

# DAVIS & MCDANIEL VETERANS CARE CENTER

## APPLICATION FOR ADMISSION (CONT.)

### FINANCIAL RESOURCES

PRIVATE FUNDS (Adequate funds available to cover \$5,500/month for 6 months)

MEDICARE A # \_\_\_\_\_ MEDICARE REPLACEMENT \_\_\_\_\_  
NAME OF INSURANCE

MEDICARE B \_\_\_\_\_  
NAME OF INSURANCE

MEDICARE D \_\_\_\_\_  
NAME OF INSURANCE

PRIVATE INSURANCE OR MEDICARE SUPPLEMENT \_\_\_\_\_  
NAME OF INSURANCE

LONG TERM CARE INSURANCE \_\_\_\_\_  
NAME OF INSURANCE

### MEDICAID

IF YOU DO NOT HAVE AT LEAST 6 MONTHS OF LIQUID ASSETS AVAILABLE TO YOU (\$33,000), THEN YOU SHOULD APPLY FOR MEDICAID IN THE CITY/COUNTY IN WHICH YOU CURRENTLY RESIDE.

|   |                           |
|---|---------------------------|
| ARE YOU APPLYING FOR MEDICAID? <input type="checkbox"/> YES <input type="checkbox"/> NO | IF YES, WHAT CITY/COUNTY? |
| WHO IS YOUR MEDICAID CASE MANAGER/<br>SOCIAL WORKER?                                    | PHONE:                    |

IF YOU ALREADY HAVE MEDICAID, PLEASE PROVIDE YOUR MEDICAID NUMBER:

### FINANCIAL

ANTICIPATED STAY:  SHORT TERM REHAB  LONG TERM CARE

#### APPLICANT'S SOURCE OF MONTHLY INCOME

RETIREMENT PENSION \$ \_\_\_\_\_

INVESTMENT INCOME \$ \_\_\_\_\_

SOCIAL SECURITY (SSA) \$ \_\_\_\_\_

CIVIL SERVICE ANNUITY \$ \_\_\_\_\_

SUPPLEMENTAL SECURITY INCOME (SSI) \$ \_\_\_\_\_

OTHER \$ \_\_\_\_\_

#### APPLICANT'S ASSETS (Include Current Balance or Value) If applicant rents, please indicate N/A

##### REAL ESTATE (Specify Type/Location)

|                                 |                 |
|---------------------------------|-----------------|
| TYPE (Home/Vacation Home, etc.) | ESTIMATED VALUE |
| TYPE (Home/Vacation Home, etc.) | ESTIMATED VALUE |

##### PERSONAL PROPERTY (Specify type, i.e. car, boat, etc.)

|      |                 |      |                 |
|------|-----------------|------|-----------------|
| TYPE | ESTIMATED VALUE | TYPE | ESTIMATED VALUE |
| TYPE | ESTIMATED VALUE | TYPE | ESTIMATED VALUE |

##### BANK INFORMATION (Please write the current balance in the space provided)

CHECKING \$ \_\_\_\_\_  CD \$ \_\_\_\_\_  OTHER \$ \_\_\_\_\_

SAVINGS \$ \_\_\_\_\_  IRA \$ \_\_\_\_\_

# DAVIS & MCDANIEL VETERANS CARE CENTER

## APPLICATION FOR ADMISSION (CONT.)

INSURANCE POLICIES, ANNUITIES, ETC. (List only those with a cash value)

TYPE

TYPE

### CLINICAL

HOSPITAL STAY IN THE LAST 6 MONTHS?  YES  NO

IF YES, NAME AND ADDRESS OF HOSPITAL

DATES OF STAY

ADMITTED:     /     /     DISCHARGED:     /     /

REASON

SKILLED NURSING STAY IN THE LAST 6 MONTHS?  YES  NO

IF YES, NAME AND ADDRESS OF FACILITY

DATES OF STAY

ADMITTED:     /     /     DISCHARGED:     /     /

REASON

### APPLICANT'S CHOICE OF:

FUNERAL HOME (Must pick one)

HOSPITAL (We will inform EMS of preference but can't guarantee where EMS will take patient.)

### IMPORTANT INFORMATION

PLEASE NOTE THAT MEDICARE ALLOWS **UP TO** 100 DAYS PER BENEFIT PERIOD. IF YOU HAVE BEEN IN ANOTHER SKILLED NURSING FACILITY WITHIN THE LAST 60 DAYS, YOU WILL NOT HAVE THE FULL 100 DAYS AVAILABLE. YOU MAY NOT UTILIZE ALL 100 DAYS IN ANY GIVEN SKILLED NURSING STAY.

PLEASE DO NOT BRING ANY MEDICATIONS INTO THE FACILITY. WE DISPENSE FROM OUR OWN PHARMACY AND CANNOT ACCEPT MEDICATIONS FROM A SOURCE OTHER THAN OUR PHARMACY.

### DECLARATION OF CONFIRMATION

I/We hereby confirm that all information stated in this document is current and correct to the best of my/our knowledge and no requested information has been withheld or misrepresented. I/We authorize Davis & McDaniel Veterans Care Center (DMVCC) to verify any of the above information. I/We understand that falsification of the stated information may jeopardize admission into DMVCC. All information will be kept confidential by DMVCC and will not be released without my written permission.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**DAVIS & MCDANIEL VETERANS CARE CENTER**  
**REPORT OF PHYSICAL EXAMINATION FOR PLACEMENT**

*Must be completed by physician within 30 days prior to admission. If admission is delayed beyond 30 days, addendum will be requested.*

NAME \_\_\_\_\_ PHONE \_\_\_\_\_ DATE OF EXAM \_\_\_\_\_

ADDRESS \_\_\_\_\_

RESIDENT'S: HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ BP \_\_\_\_\_

CURRENT DIAGNOSES/PROBLEMS

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SIGNIFICANT MEDICAL HISTORY

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GENERAL PHYSICIAN CONDITIONS/SYSTEMS REVIEW

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# DAVIS & MCDANIEL VETERANS CARE CENTER

## REPORT OF PHYSICAL EXAMINATION FOR PLACEMENT

### PRN MEDICATIONS

PATIENT'S NAME \_\_\_\_\_

As needed medications (known in healthcare as PRN medications) must include symptoms/indication for use, exact timeframes the medication is to be given in a 24-hour period, and directions for what to do if symptoms persist. All PRN medications must be available individually for each resident.

DMVCC has adopted the following over the counter medications to alleviate symptoms of temporary conditions. If symptoms are not relieved or worsen, the Primary Care Provider (PCP) or VA Medical Center (VAMC) Emergency Room (ER) physician will be notified. Please check approved orders or write in others.

1. For mild pain or temp. of 101° or higher:  
 Tylenol 650 mg. PO every 4 hours PRN. Maximum of 6 doses per 24 hours.  
 \_\_\_\_\_
2. For constipation:  
 Milk of Magnesia 30 mL PO daily PRN  
 \_\_\_\_\_  
 Fleet's enema x 1 PRN
3. For diarrhea:  
 Licensed nurse to check for fecal impaction.  
 If none present, may give Imodium AD 2 caplets PO. May repeat 1 caplet after each loose stool up to a maximum dose of 16 mg. (8 caplets) within a 24 hour period.  
 \_\_\_\_\_
4. For nausea, vomiting, acid indigestion, or upset stomach:  
 Mylanta 15 mL PO every 2 hours PRN for acid indigestion.  
 \_\_\_\_\_  
 Emetrol 15 mL every 15 minutes PRN for nausea and vomiting up to a maximum of 5 doses in 24 hours.  
 \_\_\_\_\_
5. For cough/cold symptoms:  
 Guaifenesin-DM Sugar-Free 10 mL PO every 4 hours PRN. Maximum of 4 doses in 24 hour period.  
 \_\_\_\_\_
6. For difficulty sleeping:  
 Benadryl 25 mg. PO at bedtime PRN.  
 \_\_\_\_\_
7. For minor skin tears and abrasions:  
 Clean area with normal saline daily until healed. Apply Bacitracin Ointment and clean dry dressing daily.  
 \_\_\_\_\_
8. For shortness of breath:  
 Check vital signs and pulse ox, start O2 at 2 LPM, and notify MD.  
 \_\_\_\_\_

**Unless DMVCC is notified of changes, these orders will be used for admission orders.**

Signature of MD \_\_\_\_\_ Date \_\_\_\_\_

**DAVIS & MCDANIEL VETERANS CARE CENTER**  
**REPORT OF PHYSICAL EXAMINATION FOR PLACEMENT**  
**OTHER SCHEDULED OR PRN MEDICATIONS**

PATIENT'S NAME \_\_\_\_\_

|                             |      |                     |           |
|-----------------------------|------|---------------------|-----------|
| NAME                        | DOSE | ROUTE               | FREQUENCY |
| SPECIFIC INDICATION FOR USE |      | IF SYMPTOMS PERSIST |           |

|                             |      |                     |           |
|-----------------------------|------|---------------------|-----------|
| NAME                        | DOSE | ROUTE               | FREQUENCY |
| SPECIFIC INDICATION FOR USE |      | IF SYMPTOMS PERSIST |           |

|                             |      |                     |           |
|-----------------------------|------|---------------------|-----------|
| NAME                        | DOSE | ROUTE               | FREQUENCY |
| SPECIFIC INDICATION FOR USE |      | IF SYMPTOMS PERSIST |           |

|                             |      |                     |           |
|-----------------------------|------|---------------------|-----------|
| NAME                        | DOSE | ROUTE               | FREQUENCY |
| SPECIFIC INDICATION FOR USE |      | IF SYMPTOMS PERSIST |           |

|                             |      |                     |           |
|-----------------------------|------|---------------------|-----------|
| NAME                        | DOSE | ROUTE               | FREQUENCY |
| SPECIFIC INDICATION FOR USE |      | IF SYMPTOMS PERSIST |           |

|                             |      |                     |           |
|-----------------------------|------|---------------------|-----------|
| NAME                        | DOSE | ROUTE               | FREQUENCY |
| SPECIFIC INDICATION FOR USE |      | IF SYMPTOMS PERSIST |           |

|                             |      |                     |           |
|-----------------------------|------|---------------------|-----------|
| NAME                        | DOSE | ROUTE               | FREQUENCY |
| SPECIFIC INDICATION FOR USE |      | IF SYMPTOMS PERSIST |           |

|                             |      |                     |           |
|-----------------------------|------|---------------------|-----------|
| NAME                        | DOSE | ROUTE               | FREQUENCY |
| SPECIFIC INDICATION FOR USE |      | IF SYMPTOMS PERSIST |           |

**Unless DMVCC is notified of changes, these orders will be used for admission orders.**

Signature of MD \_\_\_\_\_ Date \_\_\_\_\_

# DAVIS & MCDANIEL VETERANS CARE CENTER

## REPORT OF PHYSICAL EXAMINATION FOR PLACEMENT

PATIENT'S NAME \_\_\_\_\_

| CONDITION/CARE NEED  | YES | NO | COMMENT  |
|--|-----|----|--|
| Ventilator dependency  |     |    |  |
| Pressure Ulcer, Stage III or IV  |     |    | If stage III, is it healing?   |
| IV therapy or IV injections  |     |    | If intermittent IV therapy, check yes and indicate expected time period.                             |
| Airborne infectious disease that requires isolation or special precautions |     |    |  |
| Psychotropic medications without appropriate diagnosis and treatment plans |     |    |  |
| Nasogastric tubes  |     |    |  |
| Gastric tubes  |     |    | If yes, is the person capable of independently feeding him/herself and caring for the tube and site? |
| Presents imminent physical threat or danger to self or others              |     |    | In need of immediate assessment by a qualified mental health professional.                           |
| Requires continuous licensed nursing care                                  |     |    | Licensed nurse must provide specific needed care each shift.   |

Has the applicant exhibited any of the above behavior(s) in the past year requiring assessment, treatment, or monitoring? YES \_\_\_\_\_ NO \_\_\_\_\_ If yes, check behaviors identified:

- Physically assaulting others
- Gesturing a threat of assault
- Verbalizing a threat of harm to self or others
- Suicidal ideation or attempts
- Verbalizing an unrealistic fear of being harmed by others
- Destroying property that exposes self or others to harm
- Wandering inside or outside current residence
- Being intrusive in the personal space of others
- Putting objects or liquids in the mouth that are mistaken as food or consumable fluids
- Increased physical activity such as floor pacing that might indicate anxiety or stress
- Increased or confusing speech pattern or communications that might indicate a disorder of thought process
- Decreased physical activity such as staying in bed, not eating, or not communicating that might indicate depression
- Self-neglect - bathing, grooming, clean clothing, clean environment
- Pattern of alcohol abuse
- Pattern of drug abuse or misuse
- Compulsive behavior patterns
- Other \_\_\_\_\_

Is applicant capable of making financial decisions? Y N      Medical decisions? Y N

Signature of MD \_\_\_\_\_ Date \_\_\_\_\_

**DAVIS & MCDANIEL VETERANS CARE CENTER**  
**REPORT OF PHYSICAL EXAMINATION FOR PLACEMENT**  
**TUBERCULOSIS SCREENING EVALUATION**

PATIENT'S NAME \_\_\_\_\_

**ATTENTION CARE PROVIDERS: PPD is no longer accepted. A chest x-ray within 30 days of admission is now required to rule out communicable diseases.**

Date of most recent Mantoux tuberculin skin test \_\_\_\_\_

Result: mm of duration \_\_\_\_\_

Applicant previously tested positive

Previously treated \_\_\_\_\_

Is person exhibiting any TB-like symptoms? YES \_\_\_\_\_ NO \_\_\_\_\_

If TB skin test is 10mm or greater (5mm in HIV infected), previously positive, or if TB-like symptoms exist, respond to the following:

Date of last chest x-ray \_\_\_\_\_ (Attach report)

Was chest x-ray suggestive of active TB? YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, were sputum smears collected for AFB? YES \_\_\_\_\_ NO \_\_\_\_\_

Were three consecutive smears negative or AFB? YES \_\_\_\_\_ NO \_\_\_\_\_

Based on the above, is this individual free of communicable TB? YES \_\_\_\_\_ NO \_\_\_\_\_

**Name of licensed MD, nurse practitioner, or local health department official completing evaluation:**

PRINT NAME \_\_\_\_\_

PHONE \_\_\_\_\_

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

# **DAVIS & MCDANIEL VETERANS CARE CENTER**

## **ADVANCE DIRECTIVE & DO NOT RESUSCITATE ORDERS**

### **WHAT IS AN ADVANCED DIRECTIVE?**

An advance directive tells your doctor what kind of care you would like to have if you become unable to make medical decisions (if you are in a coma, for example). If you are admitted to the hospital, the hospital staff will probably talk to you about advance directives.

A good advance directive describes the kind of treatment you would want depending on how sick you are. For example, the directives would describe what kind of care you want if you have an illness that you are unlikely to recover from, or if you are permanently unconscious. Advance directives usually tell your doctor that you don't want certain kinds of treatment. However, they can also say that you want a certain treatment no matter how ill you are.

Advance directives can take many forms. Laws about advance directives are different in each state. Virginia has an advance directive form. This form can be obtained from the social workers at Davis & McDaniel Veterans Care Center.

### **WHAT IS A LIVING WILL?**

A living will is one type of advance directive. It is a written, legal document that describes the kind of medical treatments or life sustaining treatments you would want if you were seriously or terminally ill. A living will doesn't let you select someone to make decisions for you.

### **WHAT IS A DURABLE POWER OF ATTORNEY FOR HEALTH CARE?**

A durable power of attorney (DPA) for health care is another kind of advance directive. A DPA states whom you have chosen to make health care decisions for you. It becomes active any time you are unconscious or unable to make medical decisions. A DPA is generally more useful than a living will, but a DPA may not be a good choice if you don't have another person you trust to make these decisions for you.

Living wills and DPAs are legal in most states. Even if they aren't officially recognized by the law in your state, they can still guide your loved ones and doctor if you are unable to make decisions about your medical care. Ask your doctor, lawyer, or state representative about the law in your state.

### **WHAT IS A DO NOT RESUSCITATE ORDER?**

A do not resuscitate (DNR) order is another kind of advance directive. A DNR is a request not to have cardiopulmonary resuscitation (CPR) if your heart stops or if you stop breathing. (Unless given other instructions, hospital staff will try to help all patients whose heart has stopped or who have stopped breathing.) You can use an advance directive form or tell your doctor that you don't want to be resuscitated. In this case, a DNR order is put in your medical chart by your doctor. DNR orders are accepted by doctors and hospitals in all states.

### **SHOULD I HAVE AN ADVANCE DIRECTIVE?**

By creating an advance directive, you are making your preferences about medical care known before you're faced with a serious injury or illness. This will spare your loved ones the stress of making decisions about your care while you are sick. Any person 18 years of age or older can prepare an advance directive.

# DAVIS & MCDANIEL VETERANS CARE CENTER

## ADVANCE DIRECTIVE & DO NOT RESUSCITATE ORDERS (CONT.)

People who are seriously or terminally ill are more likely to have an advance directive. For example, someone with terminal cancer might write that she does not want to be put on a respirator if she stops breathing. This action can reduce her suffering, increase her peace of mind and increase her control over her death. However, even if you are in good health, you might want to consider writing an advance directive. An accident or serious illness can happen suddenly, and if you already have a signed advance directive, your wishes are more likely to be followed.

### HOW CAN I WRITE AN ADVANCE DIRECTIVE?

You can write an advance directive in several ways:

- Use a form provided by your doctor.
- Write your wishes down by yourself.
- See the social worker at Davis & McDaniel Veterans Care Center.
- Call your health department or state department on aging to get a form.
- Call a lawyer.
- Use a computer software package for legal documents.

Advance directives and living wills do not have to be complicated legal documents. They can be short, simple statements about what you want done or not done if you can't speak for yourself. Remember, anything you write by yourself or with a computer software package should follow your state laws.

You may also want to have what you have written reviewed by your doctor or a lawyer to make sure your directives are understood exactly as you intended. When you are satisfied with your directives, the orders should be notarized if possible, and copies should be given to your family and your doctor.

### CAN I CHANGE MY ADVANCE DIRECTIVES?

You may change or cancel your advance directive at any time, as long as you are considered of sound mind to do so. Being of sound mind means that you are still able to think rationally and communicate your wishes in a clear manner. Again, your changes must be made, signed and notarized according to the laws in your state. Make sure that your doctor and any family members who knew about your directives are also aware that you have changed them.

If you do not have time to put your changes in writing, you can make them known while you are in the hospital. Tell your doctor and any family or friends present exactly what you want to happen. Usually, wishes that are made in person will be followed in place of the ones made earlier in writing. Be sure your instructions are clearly understood by everyone you have told.

*Information Source: American Academy of Family Physicians*

**I have reviewed Advance Directive & Do Not Resuscitate information.**

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Signature of Responsible Party

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Date

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DMVCC Staff/Title

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Date