Please complete with the patient's demographic information

Full Name (Last, First, Middle): _____

Address: _____

City/State/Zip: _____

Date of Birth (mm/dd/yyyy): _____/_____/_____

Last 4 SSN: _____ _____ _____ _____ Sex: M_____ F_____

WV e-Directive Registry HTTPS://WVENDOFLIFE.ORG/REGISTRY

Surrogate Selection forms are automatically opted-in to the WV e-Directive Registry and released to treating health care providers unless opted-out by the patient or the patient's legal health care surrogate. The WV e-Directive Registry makes your forms immediately available to your health care providers in emergencies.

Registry toll-free number: 877-209-8086 **Registry FAX: 844-616-1415**

STATE OF WEST VIRGINIA
CHECKLIST FOR SURROGATE SELECTION

(In accordance with the West Virginia Health Care Decisions Act)
W.V. Code - § 16-30-8

Patient's Name: _____

Patient's Date of Birth: _____ / _____ / _____

A. DETERMINATION IF HEALTH CARE DECISIONS ACT APPLICABLE

1. Is this patient an adult (over the age of 18), an emancipated minor, or a mature minor?

Yes ____ No ____

If no, stop now. The Health Care Decisions Act of 2000 does not apply to selecting a surrogate to make decisions for children. An emancipated minor is a person over the age of 16 who has been declared emancipated by a judge or who is over the age of 16 and married. A mature minor is a person less than 18 years of age who has been determined by a qualified physician, a qualified psychologist, a physician assistant, or an advanced practice registered nurse to have the capacity to make health care decisions.

2. Has the patient been declared "incapacitated"?

Yes ____ No ____

If no, stop now. Make the decision with the patient. ("Incapacity" means the inability because of physical or mental impairment to appreciate the nature and implications of a health care decision, to make an informed choice regarding the alternatives presented, and to communicate that choice in an unambiguous manner.)

If yes, complete section 3 (below) with the details for determination of incapacity.

3. The determination of incapacity must be made by the attending physician, a qualified physician, a qualified psychologist, a physician assistant, or an advanced practice registered nurse.

MD/DO/APRN/PA name (**print**) _____

Date _____ / _____ / _____ Time _____

a. Cause: _____

b. Nature: _____

c. Duration: _____

Was the determination made regardless of age and disability? **Yes ____ No ____**

If no, the patient must be reevaluated without a presumption of incapacity.

Does this patient have a court-appointed guardian with the authority to make health care decisions or Medical Power of Attorney (MPOA)? **Yes ____ No ____**

(Note that one physician, one licensed psychologist, one physician assistant, or one advanced practice registered nurse who has personally examined the patient must document incapacity for the Medical Power of Attorney to be in effect.)

If yes, the guardian or MPOA representative is authorized to make health care decisions for the patient.

Is the guardian or representative named in the MPOA available and willing to serve?

Yes ____ No ____

If yes, stop and follow the directives of the guardian or representative in accordance with the patient's wishes, or if unknown, best interest. If the patient has a guardian or MPOA representative, selection of a surrogate is not authorized by state law. If neither a guardian nor an MPOA representative is available and willing to serve, proceed with surrogate selection.

Patient Name: _____ DOB: _____

B. SELECTION OF A SURROGATE

4. Identification of potential surrogates (If yes, enter name(s) in order of priority). Does the patient have:

   a. Spouse? Name: _____

   b. Any adult child of the patient? Names: _____

   c. Either parent of the patient? Names: _____

   d. Any adult sibling of the patient? Names: _____

   e. Any adult grandchild of the patient? Names: _____

   f. A close friend of the patient? Names: _____

   g. Such other persons or classes of persons including, but not limited to, such public agencies, public guardians, other public officials, public and private corporations, and other representatives as the department of health and human resources may from time to time designate? Names: _____

5. Who is best qualified to act as surrogate? **Name: _____**
   Why? Does this person:
   a. Know the patient's wishes, including religious and moral beliefs? **Yes ____ No ____**
      If yes, basis: _____
      _____
      _____

   b. Know the patient's best interests? **Yes ____ No ____**
      The determination of knowing the patient's best interests was based on a discussion regarding (check if yes):
      1. The patient's medical condition ____
      2. Prognosis ____
      3. The dignity and uniqueness of the patient ____
      4. The possibility and extent of preserving the patient's life ____
      5. The possibility of preserving, improving or restoring the patient's functioning ____
      6. The possibility of relieving the patient's suffering ____
      7. The balance of the burdens to benefits of the proposed treatment or intervention ____
      8. and, such other concerns and values as a reasonable individual in the patient's circumstances would wish to consider ____

   c. Have regular contact with patient? **Yes ____ No ____**
      If yes, enter nature and frequency of contact:

Patient Name: _____ DOB: _____

d. Demonstrate care and concern for the patient? Yes _____ No _____
If yes, enter the basis for this decision:

e. Visit the patient regularly during the illness? Yes_____ No_____

f. Engage in FACE-TO-FACE contact with the caregivers? Yes_____ No_____

g. Fully participate in the decision-making process? Yes_____ No_____

6. Is person available and willing to serve as surrogate? Yes_____ No_____
If no, select the best qualified person who is available and willing to serve and enter their name

7. Is this person the highest person in the list from #4? Yes_____ No_____
If no, or if there are several persons at the same priority level, enter the reasons why the selected person is more qualified under factors 5 a-g above.

_____

_____

_____

8. If conscious, the patient must be notified of the determination of incapacity and who the patients surrogate will be.

Date and time when notified: _____

Record patient response: _____

9. If the determination of incapacity is for a patient with psychiatric mental illness, intellectual disability, or substance use disorder and the treatment to be authorized by the surrogate is for mental illness, incapacity must be confirmed by another physician or licensed psychologist who has examined the patient. Is this necessary for this case?
Yes _____ No_____

10. If yes, has this been done? Yes_____ No_____
If so, name of second health care professional declaring the patient incapacitated
_____

11. Were other potential surrogates notified of surrogate selection? Yes_____ No_____
If yes, enter names, date, time and by whom they were contacted.

Name	Date	Time	Contacted by

Patient Name: _____ DOB: _____

12. If a family member/close friend who was not selected disagrees with the surrogate chosen, inform them it is their responsibility to:
    a. Notify the attending physician in writing. _____ (Initial when completed)
    b. Go to court to challenge the selection of the surrogate. _____ (Initial when completed)

13. Did any potential surrogate object? Yes _____ No_____

    If yes, enter name and basis for objection: _____

    _____

    _____

14. Inform the person who objects that they have 72 hours to obtain a court order.

    Date _____ and time _____ notified.

I HAVE COMPLETED OR REVIEWED THIS FORM AND MADE THE DECISION TO APPOINT

_____ AS SURROGATE WHO CAN BE REACHED AT THE FOLLOWING PHONE NUMBER(S)

_____ (home) _____ (work) _____ (mobile)

_____

Physician, Physician Assistant, or Advanced Practice Registered Nurse Signature / Date / Time

_____

Signature of person assisting the physician, physician assistant, or Advanced Practice Registered Nurse in completing this form (if any).

Acceptance of Surrogate Selection

I accept the appointment as surrogate for _____

(patient's name)

and understand I have the authority to make all medical decisions for _____.

(patient's name)

_____

Signature of Surrogate