**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 patients' forms immediately available to their health care providers in emergencies.

**Registry Phone: 304-293-0695** **Registry Fax: 844-616-1415**

# STATE OF WEST VIRGINA
# CHECKLIST FOR SURROGATE SELECTION

(In accordance with the West Virginia Health Care Decisions Act)
W.V. Code- §16-30-1 *et seq*

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 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 health care decisions, to make an informed choice regarding the alternatives presented, and to communicate that choice in an unambiguous manner.)

Patient Name: _____ DOB: _____

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 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 a Medical Power of Attorney (MPOA)? Yes ____ No____

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 a MPOA representative is available and willing to serve, proceed with surrogate selection.

*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.*

Patient Name: _____ DOB: _____

## B. SELECTION OF A SURROGATE

4. Identification of potential surrogates (If yes, enter names(s) in order of priority).

   Does the patient have:

   a. Spouse? Name: _____

   b. Any adult children 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 person including, but not limited to, such public agencies, public guardians, other public officials, publics and private corporations, and other representatives as the Department of Human Services 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 the 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 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 patient's surrogate will be.
Date and time when notified: _____
Record patient's response: _____

9. If the determination of the incapacity by the attending physician or a qualified physician 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 one of these conditions, 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 name, 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 or Advanced Practice Registered Nurse Signature / Date / Time

_____
Signature of person assisting the Physician 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