WEST VIRGINIA Department of Health & Human Resources

West Virginia Department of Health and Human Resources
Voluntary NonOpioid Advanced Directive

PATIENT'S LAST NAME		
PATIENT'S FIRST NAME		PATIENT'S MIDDLE NAME OR INITIAL
DATE OF BIRTH (MM/DD/YYYY)		

STREET OR RESIDENTIAL ADDRESS		
CITY	STATE	ZIP CODE (5 or 9 digits) –

LAST NAME OF GUARDIAN OR HEALTH CARE AGENT (If applicable)	
FIRST NAME OF GUARDIAN OR HEALTH CARE AGENT	MIDDLE NAME OR INITIAL

PATIENT/GUARDIAN/HEALTH CARE AGENT STATEMENT (SIGNATURE AND DATE REQUIRED)

I _____ ☐ patient ☐ guardian ☐ health care agent certify that I am refusing at my own insistence the offer or administration of any opioid medications including in an emergency situation where I am unable to speak for myself. I understand the risks and benefits of my refusal, and hereby release the health care provider(s) or emergency medical service(s), their administration and personnel, from any responsibility for all consequences, which may result by my abstinence under these circumstances. I further certify my understanding that I may effectively revoke this certification at any time orally or in writing.

I hereby direct that health care provider(s) or emergency medical service(s), their administration and personnel, comply with the West Virginia Department of Health and Human Resources Voluntary NonOpioid Advanced Directive (VNOAD) regulations and guidance with regard to the above named patient.

_____ _____

Signature of Patient/Guardian/Health Care Agent Date

SIGNATURE AND DATES (ALWAYS REQUIRED)

I am a health care practitioner for the above-named patient. I verify that the above-named patient has a current and valid VNOAD, issued on_____.

_____

Signature of Health Care Practitioner

Print Name of Health Care Practitioner

Effective Date of VNOAD Certification

_____ _____

Address of Health Care Practitioner

Telephone Number of Health Care Practitioner

First Copy: To be kept by patient

Second Copy: To be kept in patient's permanent medical record

If the person completing this form is currently enrolled in substance use treatment, appropriate consents must comply with HIPAA and 42 CFR Part 2.

For More Information: 304-558-8886 | dhhr.wv.gov