



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

PATIENT'S LAST NAME		PATIENT'S MIDDLE NAME OR INITIAL
PATIENT'S FIRST NAME		
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)		MIDDLE NAME OR INITIAL
FIRST NAME OF GUARDIAN OR HEALTH CARE AGENT		

**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 | [dhr.wv.gov](http://dhr.wv.gov)