**VALLEY HEALTH SYSTEMS, INC.**
**VOLUNTARY NON-OPIOID ADVANCE DIRECTIVE**

Patient's Name: _____ DOB: _____/_____/_____
Last First MI mm/dd/yyyy

Address: _____
Street or Residential Address

_____
Street or Residential Address

_____
City State Zip Code

Name of Guardian or Medical Power of Attorney (if applicable):

_____
Last First MI

I, _____, (☐ patient ☐ guardian ☐ MPOA) certify I am refusing at my own insistence the offer or administration of any opioid medication 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 my health care provider(s), its 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 either orally or in writing.

_____ _____
Signature of Patient/Guardian/MPOA Date

**SIGNATURE AND DATE (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 Voluntary Non-Opioid Directive (VNOD) issued and effective on _____.

_____
Signature of Health Care Practitioner

_____

Print Name of Health Care Practitioner

_____

Address of Health Care Practitioner

_____

Telephone Number of Health Care Practitioner