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