

VIRGINIA ADVANCE DIRECTIVE SUPPLEMENT FOR MENTAL HEALTH CONDITIONS

I, _____, willingly and voluntarily
Printed Name of Individual Making This Supplement for Mental Health Care (Declarant)
make known my wishes in the event that I am incapable of making an informed decision about my health care. This document is intended to supplement my advance directive for health care, which I executed on _____.
Insert Date

This document includes specific instructions to govern my health care if I am experiencing a mental health crisis.

I: SPECIAL POWERS OF MY AGENT TO AUTHORIZE HEALTH CARE OVER MY OBJECTION

This section includes my specific instructions about my health care if I am objecting to health care that my health care agent and my physician believe I need.

(CROSS THROUGH ANY POWERS YOU DO NOT WANT TO GIVE YOUR AGENT.)

The powers of my agent shall include the following:

1. To authorize my admission to a health care facility for the treatment of mental illness as permitted by law, even if I object.
2. To authorize other health care that is permitted by law and that my health care agent and my physician believe I need, even if I object. This would include any type of health care unless I have indicated otherwise by my specific instructions written in this document, in my advance directive, or in the space below.

I do not authorize these specific types of health care:

[TO GIVE YOUR AGENT ANY OF THE POWERS SET FORTH ABOVE, YOUR PHYSICIAN OR LICENSED CLINICAL PSYCHOLOGIST MUST SIGN THE STATEMENT IN THE BOX BELOW.]

I am a physician or licensed clinical psychologist familiar with the person who has made this advance directive supplement for health care. I attest that he or she is presently capable of making an informed decision and that he or she understands the consequences of the special powers given to his/her agent by this Section I of this advance directive supplement.

Physician or Licensed Clinical Psychologist Signature

Date

Physician or Licensed Clinical Psychologist Printed Name and Address

II: ADDITIONAL MENTAL HEALTH CARE INSTRUCTIONS, IF ANY

(IF YOU WANT TO GIVE ADDITIONAL INSTRUCTIONS ABOUT YOUR MENTAL HEALTH CARE, YOU MAY DO SO HERE. YOU MAY USE THIS SECTION TO DIRECT YOUR MENTAL HEALTH CARE EVEN IF YOU DO NOT HAVE AN AGENT. IF YOU DO NOT GIVE SPECIFIC INSTRUCTIONS, YOUR MENTAL HEALTH CARE WILL BE BASED, TO THE EXTENT ALLOWED BY LAW, ON YOUR VALUES AND WISHES, IF KNOWN, AND OTHERWISE ON YOUR BEST INTERESTS.)

A. I specifically direct that I receive the following mental health care if it is medically appropriate:

B. I specifically direct that I not receive the following mental health care:

C. *[INSTEAD OF WRITING INSTRUCTIONS ON THIS FORM, YOU MAY DIRECT THAT YOUR MENTAL HEALTH CARE BE PROVIDED IN ACCORDANCE WITH A CRISIS PLAN. IF YOU HAVE PREPARED A CRISIS PLAN, CHECK THE FOLLOWING BOX AND ATTACH THE CRISIS PLAN TO THIS DOCUMENT.]*

I direct that my care be provided in conformity with the preferences I have expressed in the accompanying crisis plan to the extent authorized by law.

AFFIRMATION AND RIGHT TO REVOKE: By signing below, I affirm that I understand this advance directive supplement for mental health care and that I am willingly and voluntarily executing it. I also understand that I may revoke all or any part of it at any time as provided by law.

Date _____ Signature of Declarant _____

The declarant signed the foregoing advance directive in my presence. *[TWO ADULT WITNESSES NEEDED]*

Witness Signature _____ Witness Printed _____

Witness Signature _____ Witness Printed _____

NOTE: THIS ADVANCE DIRECTIVE SUPPLEMENT FOR MENTAL HEALTH CARE SHOULD BE KEPT WITH YOUR GENERAL ADVANCE DIRECTIVE.

This form satisfies the requirements of Virginia's Health Care Decisions Act. If you have legal questions about this form or would like to develop a different form to meet your particular needs, you should talk with an attorney. It is your responsibility to provide a copy of your advance medical directive to your treating physician. You also should provide copies to your agent, close relatives and/or friends.

*This form is provided by the Virginia Hospital & Healthcare Association as a service to its members and the public. (March 2010, www.vhha.com) ▲***