You may include any or all of the parts of this advance directive that you want. Cross out or leave blank any parts that you do not want to use.

As long as it is signed and witnessed (on page 6), you may use any or all of Parts A - G to direct your mental health care. You may skip over or cross out any parts that you do not want to fill out. You can use these parts even if you do not have an agent.

Part A lets you provide background information to your treatment providers. It includes no instructions.

If you have symptoms that show you need mental health care, you can write them here and on page 3.

You can also provide medication information by attaching a list of your medications to this AD. Or you can write where/how people can get your medication information in box A.3 (e.g., calling your primary care doctor).

VIRGINIA ADVANCE DIRECTIVE FOR MENTAL HEALTH CARE

I, _____(date of birth: _____), make this advance directive in case I am not able to make mental health care decisions for myself. This advance directive says what I do want and what I do not want for my mental health care.

My health care agent, if I have one, and any treatment providers working with me are directed to provide care in line with my stated instructions and preferences. *I understand that my providers do not have to follow preferences or instructions that are medically or ethically inappropriate or against the law.*

I understand that it is important for me to keep this document up-to-date so that it provides an accurate picture of my condition, needs, instructions, and preferences.

A. My Health Conditions and Current Treatments

1. My current health condition(s) and important things about my condition(s) that treatment providers should know:

2. My medications and dosages as of _____/_____/20____:

Medication	Dose	How/when I take it

☐ See back of this page for more ☐ See attached list for more

3. Other important information regarding medications (allergies, side effects):

The information in your AD may be shared by your health care provider with other health care providers so that treatment can be given in line with your AD. You can help your different providers get in contact with each other by providing their phone numbers here.

B. Information Sharing

My current providers, who have information to help with my care, are:

Name	Provider type (e.g., PCP, psychiatrist)	Phone number

C. Emergency Contacts

I authorize the health care providers and other people helping me to contact my health care agent. This authorization includes if I am admitted to a mental health facility.
I also authorize them to contact the following people to share information about my location, condition and needs:

Name:_____ Relationship to me: _____

Ph. No. (home): _____ (cell):_____

Ph. No. (work): _____ Email: _____

Home Address:_____

Limit of details to share: _____

Name:_____ Relationship to me: _____

Ph. No. (home): _____ (cell):_____

Ph. No. (work): _____ Email: _____

Home Address:_____

Limit of details to share: _____

Part D lets you give your preferences for medications. You may refer to specific medications or types of medications.

Your physician must consider your preferences. But medication decisions must be based on your physician's clinical judgment too.

Your physician is not required to follow preferences that are medically or ethically inappropriate.

D. Medication

1. Medication Preferences

I prefer that the following medications (or classes or types of medication) be tried <u>first</u> in a crisis or emergency:

Medication name or class	As treatment for…

You have the option of telling providers a little bit about your choices—it can help them to better follow your wishes.

In general, your agent cannot authorize and your physician cannot order use of the medications that you refuse here. There are some narrow exceptions permitted by law, such as emergencies.

You may leave the option open for your agent to consent to a refused medication if circumstances indicate the medication really is the most appropriate one under the circumstances.

I prefer these medications because:

2. Medication Authorization and Refusal

General authorization to consent to medications: Generally, I authorize my agent to consent to medications that my treating physician says are appropriate.

Medication refusal instructions: Although I generally authorize my agent to consent to medications, I specifically do **not** consent to the medications listed below. (This includes brand-name, trade-name, or generic equivalents.)

Although I do not consent to these medications, I realize that my condition and needs may change. So, I also state whether my agent can consent to the medication if necessary. My agent should consent only if my physician finds that the medication is clearly the most appropriate treatment for me under the circumstances.

Medication name or class	As treatment for…	My agent can authorize it if necessary

You have the option of telling providers a little bit about your choices—it can help them to better follow your instructions.

You can add any other preferences about medication here, such as whether you prefer shots, pills, or liquid forms of medicines.

I do not want these medications because:

3. Additional preferences about medications:

Part E allows you to provide information about your condition and your preferences to help your agent and treatment providers meet your needs in a mental health crisis.

Your health care providers must consider your preferences relating to the location and type of care but their ability to follow them may be limited by clinical, legal and administrative requirements.

E. Mental Health Crisis Intervention

1. My Past Experience

a. Symptoms I might experience during a period of crisis:

Your health care providers must consider your preferences relating to the type of care but their ability to follow them may be limited by clinical, legal and administrative requirements.

b. Interventions that may help me:

c. Interventions or other factors that may make things worse:

2. Crisis units, inpatient facilities, and hospitals:

Your health care providers must consider your preferences relating to the location of care but their ability to follow them may be limited by clinical, legal and administrative requirements.

a. I prefer to be treated at the following facilities if 24-hour care is required:

because:

b. I prefer not to be treated at the following facilities:

because:

c. Facility staff can help me by doing the following:

d. I prefer to be transported by:

Contact information for transporter:

You can use **E.3** to show which emergency intervention you prefer if one has to be used. Rank the four types—you can rank all of them or some of them or leave this part blank.

Your health care providers must consider your preferences but their ability to follow them may be limited by clinical, legal and administrative requirements.

3. Behavioral emergency interventions: If I am in immediate danger of harming myself or other people, emergency interventions may be medically necessary. I am listing the four types of emergency interventions in order of my preference here.

____ Medication in pill or liquid form

____ Physical restraint

____ Medication by injection

____ Seclusion

If you want to, you can put details about why you put them in the order that you did—for example, "shots work quickest," "I usually take pills even in behavioral health emergency situations," or "I have had a traumatic experience that makes seclusion a very bad option for me."

You may use this space to provide any other information that is important to your care that may not be addressed above. If you need more space, you may attach additional documents. If you use attachments, you should be sure to describe them clearly here.

If you gave your agent the power to make visitation decisions, your agent must make visitation decisions based on any instructions you write here.

More information about ECT is available from groups like NAMI (https://www.nami.org/Learn-More/Treatment) and the Mayo Clinic (http://www.mayoclinic.org/tests-procedures).

You can use **Part G** to request that some tasks be taken care of while you are hospitalized.

Although expressing your wishes could be very useful, these statements do not necessarily have any legal effect. For example, your health care agent is not legally required to pay your bills.

I have put them in this order because:

F. Other Health Care Details

1. In General

2. Visitation Instructions

If I am in a health care facility, this is how I want visitation to be handled:

3. Electroconvulsive Therapy Instructions

☐ ____ A. I authorize my agent to consent to electroconvulsive therapy if my doctor(s) say that it is medically appropriate.

OR

☐ ____ B. I do not consent to electroconvulsive therapy.

G. Life Management Requests

☐ I have a crisis plan that can be found:_____

_____

1. If I am hospitalized, I would like for the following tasks to be carried out at my home:

2. If I am hospitalized, I would like the following tasks to be carried out in regard to my job and other outside activities and responsibilities:

3. If I am unable to care for my child(ren), then my first choice to care for them is:

Name: _____ Relationship: _____

Address: _____ Email: _____

Phone (home): _____ (cell): _____ (work): _____

Required Signatures

Right to Revoke: I understand that I may cancel all or part of my AD at any time that I am able to understand the consequences of doing so.

Affirmation: I am signing below to show that I understand this document and that I made it voluntarily.

_____ _____

Date Signature

The above person signed this advance directive in my presence.

_____ _____

Witness Signature Witness Printed

_____ _____

Witness Signature Witness Printed

It is your responsibility to provide a copy of your advance directive to your health care providers. You also should provide copies to your agent, close relatives and/or friends.

In addition to sharing hard copies, you are encouraged to store your advance directive in Virginia's free Advance Directive Registry located at the Virginia Department of Health website: https://www.connectvirginia.org/adr/.

If you have stored your advance directive in the Registry, initial here: _____

Two adult witnesses are needed to make your advance directive valid. Any person over the age of 18 may be a witness. This includes a spouse or relative, as well as employees of health care facilities and physician's offices who act in good faith.

This form meets 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.

Note: If you have added pages with instructions, those pages should be signed and witnessed, too.

This advance directive should be accepted in other states based on "reciprocity" laws that honor valid out of state documents. Check with your health care provider.