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____ :

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>How/when I take it</th>
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☐ See back of this page for more  ☐ See attached list for more

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

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

<table>
<thead>
<tr>
<th>Name</th>
<th>Provider type (e.g., PCP, psychiatrist)</th>
<th>Phone number</th>
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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: ______________________________________________________

D. Medication

1. Medication Preferences

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

<table>
<thead>
<tr>
<th>Medication name or class</th>
<th>As treatment for...</th>
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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 his or her clinical judgment too.

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

<table>
<thead>
<tr>
<th>Medication name or class</th>
<th>As treatment for…</th>
<th>My agent can authorize it if necessary</th>
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<tr>
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<td>Yes</td>
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I do not want these medications because:

3. Additional preferences about medications:

E. Mental Health Crisis Intervention

1. My Past Experience

a. Symptoms I might experience during a period of crisis:
2. Crisis units, inpatient facilities, and hospitals:

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:

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

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.

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.

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.
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.

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 1 Signature       Witness 1 Printed

_________________________          ____________________________
Witness 2 Signature       Witness 2 Printed

_It is your responsibility to provide a copy of your advance medical 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: ____