VIRGINIA MENTAL HEALTH POWER OF ATTORNEY FORM

IMPORTANT INFORMATION

This power of attorney authorizes another person (your agent) to make decisions for you (the principal). Your agent will be able to make decisions and act on your behalf, whether or not you are able to act for yourself.

This power of attorney does not authorize the agent to make health care decisions for you. Such powers are governed by applicable laws for Advance Directives.

You should select someone you trust to serve as your agent. Unless you specify otherwise, generally the agent's authority will continue until you die or revoke the power of attorney or the agent resigns or is unable to act for you.

If your agent is unable or unwilling to act for you, your power of attorney will end unless you have named a successor agent. You may also name a second successor agent.

This power of attorney becomes effective immediately unless you state otherwise in the Special Instructions.

If you have questions about the power of attorney or the authority you are granting to your agent, you should seek legal advice before signing this form.

The following forms are available from the National Resource Center on Psychiatric Advance Directives.

VIRGINIA ADVANCE DIRECTIVE FOR HEALTH CARE

I, _____, hereby make known my wishes if I am incapable of making an informed decision about my health care, as follows:

(YOU MAY INCLUDE ANY OR ALL OF THE PROVISIONS IN SECTIONS I AND II BELOW.)

SECTION I: APPOINTMENT AND POWERS OF MY AGENT

[CROSS THROUGH THIS ENTIRE SECTION I IF YOU DO NOT WANT TO APPOINT AN AGENT TO MAKE HEALTH CARE DECISIONS FOR YOU.]

A. Appointment of My Agent

I hereby appoint:

_____

Name of Primary Agent E-mail Address

_____

Home Address Telephone Number

as my agent to make health care decisions on my behalf as authorized in this document. If the primary agent named above is not reasonably available or is unable or unwilling to act as my agent, then I appoint as successor agent to serve in that capacity:

_____

Name of Successor Agent E-mail Address

_____

Home Address Telephone Number

I grant to my agent full authority to make health care decisions, including decisions about mental health care, on my behalf as described below. My agent shall have this authority whenever and for as long as I have been determined to be incapable of making an informed decision. In making health care decisions on my behalf, I want my agent to follow my desires and preferences as stated in this document or as otherwise known to him or her. If my agent cannot determine what health care choice I would have made on my own behalf, then I want my agent to make a choice for me based upon what he or she believes to be in my best interests. I want my agent and health care providers to use their best efforts to communicate with me about my care and to seek and consider my views and preferences.

B. Powers of My Agent

[IF YOU APPOINTED AN AGENT ABOVE, YOU MAY GIVE HIM/HER THE POWERS LISTED BELOW. YOU MAY CROSS THROUGH ANY POWERS LISTED BELOW THAT YOU DO NOT WANT TO GIVE YOUR AGENT AND ADD ANY ADDITIONAL POWERS YOU DO WANT TO GIVE YOUR AGENT.]

The powers of my agent shall include the following:

1. To consent to or refuse or withdraw consent to any type of health care, including, but not limited to, artificial respiration (breathing machine), artificially administered nutrition (tube feeding) and hydration (IV fluids), and cardiopulmonary resuscitation (CPR). This authorization specifically includes the power to consent to dosages of pain-relieving medication in excess of recommended dosages in an amount sufficient to relieve pain. This applies even if this medication carries the risk of addiction or of inadvertently hastening my death.
2. To request, receive and review any oral or written information regarding my physical or mental health, including but not limited to medical and hospital records, and to consent to the disclosure of this information as necessary to carry out my directions as stated in this advance directive.
3. To employ and discharge my health care providers.
4. To authorize my admission, transfer, or discharge to or from a hospital, hospice, nursing home, assisted living facility or other health care facility.

5. To authorize my admission to a health care facility for treatment of mental illness as permitted by law.
6. To continue to serve as my agent if I object to the agent's authority after I have been determined to be incapable of making an informed decision.
7. To authorize my participation in any health care study approved by an institutional review board or research review committee according to applicable federal or state law if the study offers the prospect of direct therapeutic benefit to me.
8. To authorize my participation in any health care study approved by an institutional review board or research review committee according to applicable federal or state law that aims to increase scientific understanding of any condition that I may have or otherwise to promote human well-being, even though it offers no prospect of direct benefit to me.
9. To make decisions regarding visitation during any time that I am admitted to any health care facility, consistent with the specific directions I have provided in Section II below.
10. To take any lawful actions that may be necessary to carry out these decisions, including the granting of releases of liability to medical providers.
11. To donate all or part of my body for transplantation, therapy, research or education.

ADDITIONAL POWERS, IF ANY: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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_____

_____

C. Special Powers of My Agent to Authorize Health Care Over My Objection

THIS PART OF SECTION I ALLOWS YOU TO AUTHORIZE YOUR HEALTH CARE AGENT TO CONSENT TO TREATMENT RECOMMENDED BY YOUR PHYSICIAN EVEN IF YOU ARE OBJECTING AT THAT TIME BECAUSE OF THE EFFECTS OF MENTAL DISORDER. IF YOU DO NOT WANT TO GIVE YOUR AGENT THIS AUTHORITY, YOU SHOULD SKIP THIS SUBSECTION OR CROSS THROUGH IT. IF YOU DO WANT TO GIVE YOUR AGENT THIS AUTHORITY, YOU SHOULD CHECK AND INITIAL THE BOXES NEXT TO THE SPECIAL POWERS YOU WANT TO GIVE YOUR AGENT. HOWEVER, THESE INSTRUCTIONS WILL NOT BE LEGALLY BINDING

UNLESS A PHYSICIAN OR CLINICAL PSYCHOLOGIST CERTIFIES THAT YOU UNDERSTAND THE CONSEQUENCES OF GIVING YOUR AGENT THESE SPECIAL POWERS.]

This subsection includes my instructions about what powers my agent will have if I am incapable of making informed decisions about my health care and I am objecting to health care that my agent and my physician believe I need.

The powers of my agent shall include the following: r ____ 1. To authorize my admission to a health care facility for the treatment of mental illness as permitted by law, even if I object. r ____ 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 all health care with the exception of the types of health care I have written in the space below or elsewhere in this document:

I do not authorize my agent to allow the following specific types of health care over my objection:

_____

_____

[TO GIVE YOUR AGENT ANY OF THE POWERS SET FORTH IN THIS SUBSECTION C, A PHYSICIAN OR LICENSED CLINICAL PSYCHOLOGIST WHO KNOWS YOU MUST SIGN THE STATE-MENT IN THE BOX BELOW.]

I am a physician or licensed clinical psychologist familiar with the person who has made this advance directive 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 Subsection C of this advance directive.

_____

Physician or Licensed Clinical Psychologist Signature Date

_____

Physician or Licensed Clinical Psychologist Printed Name and Address

SECTION II: MY HEALTH CARE PREFERENCES AND INSTRUCTIONS

This section of my Advance Directive for Health Care sets forth my preferences and instructions regarding my health care. Any health care agent that I have appointed, and any treatment providers working with me, are directed to provide care consistent with my stated instructions and preferences to the extent possible unless they are medically or ethically inappropriate or are contrary to law. I understand that it is important for me to review and update this document periodically, so that it fairly reflects my condition, my needs, and my values and preferences, and to make sure that my treatment providers and my agent have a copy of my Advance Directive.

[YOU MAY USE ANY OR ALL OF PARTS A-G IN THIS SECTION TO DIRECT YOUR HEALTH CARE EVEN IF YOU DO NOT NAME AN AGENT. IF YOU CHOOSE NOT TO PROVIDE WRIT-TEN INSTRUCTIONS, HEALTH CARE DECISIONS WILL BE BASED ON YOUR VALUES AND PREFERENCES, IF KNOWN, OR, IF YOUR VALUES AND PREFERENCES ARE NOT KNOWN, ON YOUR BEST INTERESTS. YOU DO NOT NEED TO COMPLETE EVERY PART OF THIS SECTION. JUST SKIP OVER OR CROSS OUT ANY PARTS THAT YOU DO NOT WANT TO FILL OUT.]

A. My Health Conditions and Current Treatments

[THIS PART GIVES YOU AN OPPORTUNITY TO PROVIDE BACKGROUND INFORMATION TO YOUR TREATMENT PROVIDERS. IT INCLUDES NO INSTRUCTIONS. YOU DO NOT HAVE TO FILL IT OUT.]

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

_____

_____

_____

2. Symptom(s) that indicate I need prompt medical attention: _____

_____

_____

_____

3. My current medications and dosages: _____

_____

_____

_____

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

_____

_____

_____

B. Emergency Contacts

In case of health crisis, including admission to a 24-hour mental health facility, I give consent for the following people to be contacted:

_____

Name Relationship to Me

_____

Home Address

_____

Home Phone Work Phone

_____

Name Relationship to Me

_____

Home Address

_____

Home Phone Work Phone

_____

Primary Care Physician Work Phone

_____

Other Treatment Provider Work Phone

C. Medication

[THIS PART ALLOWS YOU TO STATE YOUR PREFERENCES REGARDING USE OF MEDICATIONS IF YOU BECOME UNABLE TO MAKE INFORMED DECISIONS TO CONSENT OR REFUSE. YOU MAY REFER TO SPECIFIC MEDICATIONS OR CLASSES OF MEDICATIONS.]

1. Medication Preferences.

[YOUR PHYSICIAN IS OBLIGATED TO CONSIDER YOUR PREFERENCES, BUT MUST BASE MEDICATION DECISIONS ON HIS OR HER CLINICAL JUDGMENT ABOUT YOUR TREATMENT NEEDS, AND IS NOT REQUIRED TO FOLLOW INSTRUCTIONS THAT ARE MEDICALLY OR ETHICALLY INAPPROPRIATE.]

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

Medication or class of medications #1:_____

For treatment of the following problem or condition: _____

Reason I prefer this type of medication: _____

Medication or class of medications #2:_____

For treatment of the following problem or condition: _____

Reason I prefer this type of medication: _____

Medication or class of medications #3:_____

For treatment of the following problem or condition: _____ Reason I prefer this type of medication: _____

2. Medication Refusals.

IN GENERAL, YOUR AGENT CANNOT AUTHORIZE, AND YOUR PHYSICIAN CANNOT ORDER, ADMINISTRATION OF THE MEDICATIONS THAT YOU REFUSE BELOW EXCEPT IN NARROW CIRCUMSTANCES PERMITTED BY LAW, SUCH AS EMERGENCIES.]

I consent, or authorize my agent to consent, to administration of medications my treating physicians deem appropriate, with the exception of the following medications (or their respective brand-name, trade-name, or generic equivalents) or classes of medication which I specifically do not authorize:

Medication or class of medications #1: _____

Reason I refuse this medication: _____

Medication or class of medications #2: _____

Reason I refuse this medication: _____

Medication or class of medications #3: _____

Reason I refuse this medication: _____

3. Additional preferences about medications: _____

_____

_____

_____

D. Mental Health Crisis Intervention

[THIS PART 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 WILL 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.]

1. My Past Experience

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

_____

_____

b. Interventions that may help me:_____

_____ c.

Interventions or other factors that may make things worse: _____

_____

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:

_____

_____

_____

3. My preferences regarding behavioral emergency interventions: If I am in immediate danger of harming myself or other people, I prefer that emergency interventions be tried in the following order if they are medically necessary.

[RANK THE CHOICES BELOW IN ORDER OF YOUR PREFERENCE FROM 1 TO 4.]

____ Medication in pill or liquid form

____ Physical Restraint

____ Medication by Injection

____ Seclusion

Reasons for my preferred order: _____

_____

_____

_____

E. Other Health Care Instructions

1. In General

_____

_____

_____

2. Visitation

a. I give permission for the following people to visit me in the hospital or crisis unit:

_____

_____

_____.

b. I do not give permission for the following people to visit me in the hospital or crisis unit:

_____

_____

_____.

3. Electroconvulsive Therapy

[CHECK ONE BOX AND INITIAL EITHER A or B]: r ____ A. I do not consent to the administration of electroconvulsive therapy.

OR

r ____ B. I authorize my agent to consent to the administration of electroconvulsive therapy if clinically indicated.

4. Sharing of Information

I understand that the information in this document may be shared by my mental health treatment provider with any other mental health treatment provider who may serve me when necessary to provide treatment in accordance with this advance instruction. Other instructions about sharing of information are as follows:

_____

_____

_____

_____

F. Life Management Preferences.

[WHEN A PERSON IS HOSPITALIZED WITHOUT AN OPPORTUNITY TO MAKE SPECIFIC PLANS BEFOREHAND, MANY PROBLEMS CAN ARISE. THIS SUBSECTION ALLOWS YOU TO EXPRESS YOUR WISHES IF YOU HAVE NOT DONE SO ELSEWHERE. ALTHOUGH EXPRESSING YOUR WISHES COULD BE VERY USEFUL, THESE STATEMENTS DO NOT NECESSARILY HAVE ANY LEGAL EFFECT.]

r ____ I am not completing this section because I already have a crisis plan.

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), the following person is my first choice to care for them:

_____

Name Relationship to Me

_____

Home Address

_____

Phone (Day) Phone (Evening)

G. Life-Prolonging Treatment

[THIS SUBSECTION OF THE ADVANCE DIRECTIVE ALLOWS YOU TO EXPRESS YOUR PREFERENCES OR INSTRUCTIONS ABOUT YOUR HEALTH CARE IF YOUR DEATH IS IMMINENT (VERY SOON) OR YOUR BRAIN BECOMES SEVERELY AND PERMANENTLY DAMAGED. YOU DO NOT HAVE TO MAKE ANY SPECIFIC DECISIONS ABOUT THESE ISSUES. IF YOU HAVE APPOINTED A HEALTH CARE AGENT, HE OR SHE CAN MAKE SPECIFIC DECISIONS FOR YOU AT THE APPROPRIATE TIME. IF YOU ARE NOT SURE ABOUT YOUR PREFERENCES, DISCUSS YOUR FEELINGS AND THOUGHTS WITH YOUR HEALTH CARE AGENT, YOUR DOCTORS AND/OR OTHER PEOPLE WHO CARE ABOUT YOU.]

1. I provide the following instructions if my attending physician determines that my death is imminent (very close) and medical treatment will not help me recover:

[CHECK ONLY 1 BOX AND INITIAL ON THE ACCOMPANYING LINE.]

r □____ I do not want any treatments to prolong my life. This includes tube feeding, IV fluids, cardiopulmonary resuscitation (CPR), ventilator/respirator (breathing machine), kidney dialysis or antibiotics. I understand that I still will receive treatment to relieve pain and make me comfortable. (OR)

r□ ____ I want all treatments to prolong my life as long as possible within the limits of generally accepted health care standards. I understand that I will receive treatment to relieve pain and make me comfortable. (OR)

r ____ *[YOU MAY WRITE HERE YOUR OWN PREFERENCES AND INSTRUCTIONS ABOUT YOUR CARE WHEN YOU ARE DYING, INCLUDING SPECIFIC INSTRUCTIONS ABOUT TREATMENTS THAT YOU DO WANT, IF MEDICALLY APPROPRIATE, OR DON'T WANT. IT IS IMPORTANT THAT ANY INSTRUCTIONS YOU GIVE HERE DO NOT CONFLICT WITH OTHER INSTRUCTIONS YOU HAVE GIVEN IN THIS ADVANCE DIRECTIVE.]:*

_____

_____

_____

_____

_____

_____

_____

_____

_____

2. I provide the following instructions if my condition makes me unaware of myself or my surroundings or unable to interact with others, and it is reasonably certain that I will never recover this awareness or ability even with medical treatment.

[CHECK ONLY 1 BOX AND INITIAL ON THE ACCOMPANYING LINE.]

r □____ I do not want any treatments to prolong my life. This includes tube feeding, IV fluids, cardiopulmonary resuscitation (CPR), ventilator/respirator (breathing machine), kidney dialysis or antibiotics. I understand that I still will receive treatment to relieve pain and make me comfortable. (OR)

r □____ I want all treatments to prolong my life as long as possible within the limits of generally accepted health care standards. I understand that I will receive treatment to relieve pain and make me comfortable. (OR)

r □____ I want to try treatments for a period of time in the hope of some improvement of my condition. I suggest _____ as the period of time after which such treatment should be stopped if my condition has not improved. Any agent or surrogate may specify the exact time period in consultation with my physician. I understand that I still will receive treatment to relieve pain and make me comfortable. (OR)

r □ ____ *[YOU MAY WRITE HERE YOUR PREFERENCES AND INSTRUCTIONS ABOUT YOUR CARE WHEN YOU ARE UNABLE TO INTERACT WITH OTHERS AND ARE NOT EXPECTED TO RECOVER THIS ABILITY. THIS INCLUDES SPECIFIC INSTRUCTIONS ABOUT TREATMENTS YOU DO WANT, IF MEDICALLY APPROPRIATE, OR DO NOT WANT. IT IS IMPORTANT THAT ANY INSTRUCTIONS YOU GIVE HERE DO NOT CONFLICT WITH OTHER INSTRUCTIONS YOU HAVE GIVEN IN THIS ADVANCE DIRECTIVE.]*

_____

_____

****

AFFIRMATION AND RIGHT TO REVOKE: By signing below, I indicate that I understand this document 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

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.