INOVA®

3ADV

I, _____ _____ willingly and voluntarily
First Name Last Name Date of Birth
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 (date) _____ naming (name of agent) _____ as my agent.

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.

The powers of my agent shall include the following:
(Cross through any powers you DO NOT want to give your agent.)

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) **Physician or Licensed Clinical Psychologist** (print name) Date

_____
Physician or Licensed Clinical Psychologist Address

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ❑ Male ❑ Female

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☐ IAH ☐ IFH ☐ IFOH ☐ ILH ☐ IMVH

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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 in 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.

Patient (signature): _____ Date: _____

The person named signed this advance directive in my presence (TWO adult witnesses needed):

Witness (signature):_____ (print name): _____ Date: _____

Address: _____

Witness (signature):_____ (print name): _____ Date: _____

Address: _____

Interpreter Information (To be completed by Inova staff, if applicable)**:**

☐ In person ☐ Telephonic ☐ Video Interpreter name/ID number (if applicable) _____

☐ Patient/Designated Decision Maker was offered and refused interpreter ☐ Waiver signed

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ❑ Male ❑ Female

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