Sentara®

ADVD

Patient protest attachment—Virginia

If you wish to include the below in your Advance Care Plan (Advance Directive), a practitioner's signature is required by law, agreeing that you can make an informed decision at the time you signed the below form.

Name _____ Social security number XXX - XX - _____

Address _____ City _____ State _____ Zip _____

Phone: (_____) _____ Date of birth _____ - _____ - _____

My healthcare agent's authority in the event of my protest

When I am unable to make informed decisions about my health care, I may not agree to the care I need. In this situation, my healthcare agent, as allowed by law:

☐ Can agree to my admission to a mental healthcare facility, if my physician feels that care is medically necessary, **even if I do not agree.**

☐ Can agree to other healthcare treatment, **even if I do not agree.**

☐ **CANNOT** agree to the following healthcare:

_____

_____

Signatures (required)

By signing below, I show that I understand this document, and 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.

My signature _____ **Date** _____

Licensed Practitioner Signature

I am a licensed: physician, clinical psychologist, physician assistant, nurse practitioner, professional counselor, or clinical social worker and am familiar with the person who has made this Advance Care Plan (Advance Directive). I agree this person is currently able to make an informed decision and understands the possible results of this decision.

Practitioner's signature _____ **Date** _____

Practitioner's name (print) _____ **Phone number** _____

Witness signatures

Witness #1 (print) _____ **Signature** _____

Witness #2 (print) _____ **Signature** _____

Note:

On your Sentara Advance Care Plan (Advance Directive), please initial the box on the second page under "additional information" to show you want this form included in your Sentara Virginia Advance Care Plan (Advance Directive).

Patient label