

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 ON 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 conditions 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 supplement for mental health care in my presence. TWO ADULT WITNESSES NEEDED.

(Witness Signature) _____

(Witness Signature) _____

NOTE: This Advance Directive Supplement for Mental Health Care should be kept with your general advance directive for health care.

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. This form is provided as a service to the public by the Palliative Care Partnership of the Roanoke Valley (www.pcpv.org).