My Advance Care Plan

"Communicating My Healthcare Wishes"

Patient Protest Attachment

If you wish to include the below statement in your Advance Care Plan (Advance Directive), a physician's signature is required by law, noting that you are capable of making an informed the decision at the time that you signed this Directive.

Name: ______________________________ **Social Security Number:** **XXX – XX -** ________

Address: ___________________________ **City:** ______________ **State & ZIP:** __________

Phone: (______) _______ - ___________ **Date of Birth:** _______ - _______ - ___________

Sentara Healthcare Advance Directive
USLWR Source Code 36901001

Date: ___________________ **20**_____

MY AGENT'S AUTHORITY IN THE EVENT OF MY PROTEST:

My Healthcare Agent(s) may authorize my admission to a healthcare facility for the treatment of mental illness even over my protest.

My Healthcare Agent(s) may authorize the specific types of healthcare identified in this Advance Directive, EXCEPT ________________________________, even over my protest.

My physician or licensed clinical psychologist hereby attests that I am capable of making an informed decision and that I understand the consequences of this provision of my Advance Care Plan.

____

Physician Signature (required) ***Date***

____

Physician Name (PRINT) ***Phone Number***

____

My signature (required) **Date**

TWO WITNESS SIGNATURES REQUIRED

Print Name: ________________________________ **Signature:** ______________________________________

Print Name: ________________________________ **Signature:** ______________________________________

NOTE: This attachment is intended to be part of your Advance Care Plan (Advance Directive). Please initial the appropriate box on your Advance Care Plan to indicate it is your intention for this attachment to be included in your Advance Care Plan.