

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.