ADVANCE DIRECTIVE FOR MENTAL HEALTH CARE DECISION MAKING

Name_____SS#:_____

Part One:
Statement of Intent

I, _____, being of sound mind, willfully and voluntarily execute this health care directive to assure that during the periods of incapacity or incompetence resulting from psychiatric or physical illness; my choices regarding my mental health care will be carried out despite my inability to make informed decisions on my own behalf. In the event that a guardian or other decision maker is appointed by a court to make health care decisions for me, I intend this document to take precedence over all other means of ascertaining my intent while competent.

By this document, I intend to create an advance directive for health care as authorized by state law, the U.S. Constitution and the Federal Patient Self-Determination Act of 1990 (P.L. 101-508) to indicate my wishes regarding mental health treatment. To the extent, if any, that this document is not valid under state law, it is my desire that it be considered a statement of my wishes and that it be accorded the greatest possible legal weight and respect. It is my intention that this advance directive will become active and take effect upon my incapacity to make my own health care decisions, and shall continue in effect only during that incapacity. It is my intention that for the purposes of utilizing this directive as my wishes for treatment, that I will be considered incapacitated if two physicians deem me unable to make informed decisions on my behalf.

My wishes expressed in this document should be honored whether or not my agent dies or withdraws or if I have no agent appointed at the time of execution of this document. If I have not named an agent, these instructions shall be binding upon whomever may be appointed as my agent or decision-maker.

The fact that I may have left blanks in this advance directive (i.e. not completed certain sections) should not affect its validity in any way. I intend that all completed sections be followed. If I have not expressed a choice, my agent should make the decision that he or she determines is the decision I would make if I were competent to do so.

If any part of this advance directive is invalid or ineffective under relevant law, this fact should not affect the validity or effectiveness of the other parts. It is my intention that each part of this advance directive stand alone. Even if some parts are invalid or ineffective, I desire that all other parts be followed.

I intend this mental health care advance directive to take precedence over any and all living will documents and/or durable power of attorney for health care documents and/or other advance directives I have previously executed, to the extent that they are inconsistent with this document.

Part Two:
Appointment Of an Agent for Mental Health Care

I,_____, being of sound mind, authorize a mental health care agent to make certain decisions on my behalf regarding mental health treatment when I am incompetent to do so. I intend that those decisions should be made in accordance with my expressed wishes as set forth in this document. If I have not expressed a choice in this document, I authorize my agent to make the decision I would make if I were competent to do so. I hereby designate and appoint the following person as my agent to make mental health care decisions for me as authorized in this document. This person is to be notified immediately of my admission to a psychiatric facility.

Name: _____
Address:
_____
_____

Daytime Phone Number: _____Night Phone: _____

Agents Acceptance:
I hereby accept designation as agent for: _____
Signature: _____Witness:_____

Part Three:
Statement of My Desires, Instructions, Special Provisions and Limitations Regarding My Mental Health Treatment and Care:

1. My choice of treatment facilities:

I would prefer care at one of the following 24-hour care facilities:
_____
_____
_____

I do not wish to be treated at the following 24-hour care facilities:
_____
_____
_____

2. My choice of visitors:

I would like to restrict the following persons from visiting me during my hospitalization:
_____
_____
_____

3. My preferences regarding emergency interventions:

If it is determined that I am engaging in behavior that requires an emergency intervention, my wishes regarding which form of emergency interventions should be made are as follows. I prefer these interventions in the following order:

Please list your preferences in numerical order from 1 to 6. If you do not want a specific intervention at all, do not place any number next to it. If you do not wish to specify any emergency interventions for yourself, do not assign any numbers and note this decision in the reason section, below.

_____ seclusion
_____ physical restraints
_____ seclusion and physical restraints
_____ medication by injection
_____ medication in pill form
_____ liquid medication

Reasons for my chosen preferences: _____
_____
_____

Reasons for not assigning preferences:_____
_____
_____

4. My preferences about the physicians who will treat me if I am hospitalized:

My choice of treating physicians is:

Dr.:_____Phone Number: _____
Dr.:_____Phone Number: _____
Dr.:_____Phone Number: _____

I wish not to be treated by:
Dr.:_____
Dr.:_____

5. My preferences regarding medication for psychiatric treatment:

Please initial one or more of the following:

_____A. I consent to the medications agreed to by my agent, after consultation with my treating physician and any other individuals my agent may think appropriate, with the reservations, if any, described in (C) below

_____B. I consent to and authorize my agent to consent to the administration of:

Medication Name:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Medication Name:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

_____C. I specifically do not consent and do not authorize my agent to consent to the administration of the following medications or their respective brand-name, trade-name, or generic equivalents:

Medication Name:

_____
_____
_____
_____

Reason for Refusal:

_____
_____
_____
_____

_____D. I have the following other preferences about psychiatric medications:

_____
_____
_____
_____

6. My preferences regarding electroconvulsive therapy:

Please initial A or B:

_____A. I do not consent to the administration of electroconvulsive therapy.

_____B. I consent, and authorize my agent to consent, the administration of electroconvulsive therapy.

7. Consent for experimental studies or drug trials:

Please initial one:

_____A. I do not wish to participate in any experimental drug studies or drug trials.

_____B. I authorize my agent to consent to my participation in experimental drug studies if my agent, after consultation with my treating physician and other individuals my agent may think appropriate, determines that the potential benefit to me outweighs the possible risks of my participation and that other, nonexperimental, interventions are not likely to provide effective treatment.

FOR FEMALES WITH CHILDBEARING POTENTIAL ONLY

8. My preferences regarding my treatment should I become pregnant:

This part of the advance directive would take precedence over Part Three, Number 5 and 6, for the duration of my pregnancy:

Initial one or more of the following:

_____A. I consent to the medications agreed to by my agent for consultation with my treating physician and other individuals my agent may think appropriate, with the reservations, if any, described in (C) below.

_____B. I consent to, and authorize my agent to consent to, the administration of:

Medication Name	Medication Name
_____	_____
_____	_____
_____	_____
_____	_____

_____C. I have the following other preferences or concerns about psychiatric medication during pregnancy:

_____
_____
_____
_____
_____

Part Four:
Statement of My Preferences Regarding Notification of Others and Custody of My Minor Child(ren):

1. Who should be notified immediately of my admission to a psychiatric facility:

If I am incompetent, I desire the staff to notify the following individuals immediately that I have been admitted to a psychiatric facility:

Name:_____
Relationship:_____
Address:_____
_____
_____
Phone (Day): _____
Phone (Eve.): _____

Name:_____
Relationship:_____
Address:_____
_____
_____
Phone (Day):_____
Phone (Eve.):_____

2. My preferences for care and temporary custody for my minor children:

In the event that I am unable to care for my child(ren), I want the following person as my first choice to care for and have temporary custody of my child(ren).

Name: _____ Relationship:_____
Address: _____
_____
_____
Phone (Day):_____ Phone (Eve.):_____

Part Five:
Statement of My Preferences Regarding Revocation or Termination of This Advance Directive

1. Revocation of my psychiatric advance directive

Initial A. or B.:

_____A. My wish is that this mental healthcare directive may be revoked, suspended or terminated by me at any time, if state law so permits.

_____B. My wish is that this mental healthcare directive may be revoked, suspended or terminated by me at times I have the capacity and competence to do so. I understand that I may be choosing to give up the right to change my mind at any time. I expressly give up this right to ensure compliance with my advance directive. My decision not to be able to change this advance directive while I am incompetent or incapacitated is made to ensure that my previous, carefully considered thoughts about how I want to be treated will remain in effect during the time I am incompetent or incapacitated. Notwithstanding the above, it is my wish that my agent or other decision-maker specifically ask me about my preferences before making a decision regarding mental health care, and take the preferences I express here into account when making such a decision, even when I am incompetent or incapacitated.

2. Duration of This Psychiatric Advance Directive

Initial A. or B.:

_____A. It is my intention that this advance directive will remain in effect for an indefinite period of time.

_____B. It is my intention that this advance directive will automatically expire two years from the date it was executed.

If my choice above is not valid under state law, then it is my intention that this advance directive remain in effect for as long as the law permits.

Part Six:
Signature Page

By signing here I indicate that I understand the purpose and effect of this document.

X._____

Date:_____

The directive above was signed and declared by the Declarant,_____ to be his/her mental health care advance directive, in our presence who, at his/her request have signed names below as witnesses. We declare that, at the time of execution of this instrument, the Declarant according to our best knowledge and belief, was of sound mind and under no constraint or undue influence. We further declare that none of us is 1) a physician; 2) the Declarant's physician or employee of the Declarant's physician; 3) an employee of a patient of any residential health care facility in which the Declarant is a patient; 4) designated as agent or alternate under this document; or 5) a beneficiary or a creditor of the estate of the Declarant.

Dated at _____(County/State) this _____day of_____.

Witness Signatures:

Witness 1:
X._____
Name printed:_____
Address:_____
_____
_____

Witness 2:
X._____
Name printed:_____
Address:_____
_____
_____

Physician Statement:

I,_____, do declare that I have examined_____
_____, this_____day of _____.

I believe to a reasonable degree of medical certainty that he/she is able to understand the risks, benefits, and alternatives to the treatment wishes expressed in this advance directive.

X._____Witness:_____

(For use by the notary):
STATE OF: _____
County of: _____
Subscribed and sworn to or affirmed before me the Declarant_____ and (names of witnesses)_____
and _____, witnesses as the voluntary act and deed of the Declarant, this _____ day of_____.

My commission expires:
_____
_____