Advance Directive for Mental Health

Of

I, (your name) _____, being of sound mind, willfully and voluntarily execute this mental health care advance directive to assure that, during periods of incapacity or incompetency 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. If a guardian or an agent is appointed to make mental health decisions for me, I intend this document to take precedence over other means of ascertaining my wishes and interests.

I intend this directive to take precedence over any other mental health directives I have previously executed, to the extent that they are inconsistent with this document, or unless I expressly state otherwise in either document.

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.

I understand there are some circumstances where my provider may not have to follow my directive, specifically, if the treatment requested in this directive is infeasible or unavailable, the facility or provider is not licensed or authorized to provide the treatment requested or the directive conflicts with other applicable law.

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 1. Appointment of Agent for Mental Health Care

Make sure you give your agent a copy of all sections of this document.

Statement of Intent to Appoint an Agent:

I, (your name)_____, being of sound mind, authorize a health care agent to make certain decisions on my behalf regarding my 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 that my agent determines is the decision I would make if I were competent to do so.

1. Designation of Mental Health Care Agent

A. 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:_____
_____
_____Day Phone Number: _____
Night Phone:_____

B. Agent's Acceptance: I hereby accept the designation as agent for

(Your Name)_____

(Your Agent's Signature)_____

2. Authority Granted to My Agent (Initial if you agree with a statement; leave blank if you do not.)

A. _____ If I become incapable of giving consent to mental health care treatment, I hereby grant to my agent full power and authority to make mental health care decisions for me, including the right to consent, refuse consent, or withdraw consent to any mental health care, treatment, service or procedure, consistent with any instructions and/or limitations I have set forth in this advance directive. If I have not expressed a choice in this advance directive, I authorize my agent to make the decision that my agent determines is the decision I would make if I were competent to do so.

B._____ Having named an agent to act on my behalf, I do, however, wish to be able to discharge or change the person who is to be my agent if that agent is instrumental in the process of initiating or extending any period of psychiatric treatment against my will. My ability to revoke or change agents in

this circumstance shall be in effect even while I am incompetent or incapacitated, if allowed by law. Even if I choose to discharge or replace my agent, all other provisions of this advance directive shall remain in effect and shall only be revocable or changeable by me at a time when I am considered competent and capable of making informed health care decisions.

Part 2. Current Treatment Center and Care Coordinators

Initial below to indicate consent for emergency and crisis facilities to outreach your treatment team

A.____ If I am incompetent, I consent staff to contact my provider/treatment center in emergency situations.

Use the space below to indicate where you are currently receiving treatment.

Treatment Facility:_____

Medication Prescriber:_____

Therapist/Counselor:_____

Phone number:_____

Address:_____

Part 3. My Preferences Regarding Medications for Psychiatric Treatment

In this section, you may choose any of the paragraphs A-G that you wish to apply. Be sure to initial those you choose.

If it is determined that I am not legally competent to consent to or to refuse medications relating to my mental health treatment, my wishes are as follows:

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 (D) below.

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

Medication Name	Not to exceed the following dosage	or	In such dosage(s) as determined by
_____	_____		Dr._____
_____	_____		Dr._____
_____	_____		Dr._____
_____	_____		Dr._____

C._____ I consent to the medications deemed appropriate by Dr._____,

Whose address and phone number are:_____

_____

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

Name of Drug	Reason for Refusal
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

E._____ I am willing to take the medications excluded in (D) above if my only reason for excluding them is their side effects and the dosage can be adjusted to eliminate those side effects.

F. ____ I am concerned about the side effects of medications and do not consent or authorize my agent to consent to any medication that has any of the side effects I have checked below at a 1% or greater level of incidence (check all that apply).

_____ Tardive dyskinesia

_____ Tremors

_____ Loss of sensation

_____ Nausea/vomiting

_____ Motor restlessness

_____ Neuroleptic Malignant Syndrome

_____ Seizures

_____ Muscle/skeletal rigidity

_____ Other _____

G._____ I have the following other preferences about psychiatric medications:

_____
_____
_____

Part 3. Statement of My Preferences Regarding Notification of Others, Visitors, and Custody of My Child(ren)

1. Who Should Be Notified Immediately of My Admission to a Psychiatric Facility

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

Name:_____ Relationship: _____

Phone:_____

Name:_____ Relationship: _____

Phone:_____

Name:_____ Relationship: _____

Phone:_____

2. Who Should Be *Prohibited* from Visiting Me

I do not wish the following people to visit me while I am receiving care in a psychiatric facility:

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

3. My Preferences for Care and Temporary Custody of My Children

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

Name: _____ Relationship: _____
Address:_____City, State,
Zip:_____

Phone: (Day) _____ (Eve.)_____

In the event that I have pets to be cared for in my absence, the following preference applies:

_____ Children only

_____ Children and Pets

Part 4. Other Instructions About Mental Health Care

(Use this space to add any other instructions that you wish to have followed. If you need to, add pages, numbering them as part of this section.)

_____
_____
_____
_____
_____
_____
_____
_____
_____

Part 4. Duration of Mental Health Care Directive

Initial A or B

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

OR

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

Part 5. Signature Page

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

_____

Your Signature Date

The directive above was signed and declared by the "Declarant," (your name)_____ _____ , to be his/her mental health care advance directive, in our presence who, at his/her request, have signed names below as witness. We declare that, at the time of the 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 an employee of the Declarant's physician; 3) an employee or 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 creditor of the estate of the Declarant.

Dated at _____ (county, state), this _____ day of _____, _20___.

Witness Signature

Name of Witness (printed):

_____

Signature of Witness:

_____

Home address of Witness

_____

City, State, Zip Code of Witness:

_____