Psychiatric Advance Directive

Name: _____

Date: _____

Mental Health Care Agent:

Name: _____

Address: _____

_____

Day Phone Number: _____

Night Phone: _____

STATEMENT OF INTENT

I, *(your name)* _____, being of sound mind, willfully and voluntarily execute this Psychiatric Advance Directive to assure that, during periods of incapacity resulting from psychiatric 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 decision maker is appointed by a court to make mental 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 a Psychiatric Advance Directive as authorized by state law, the U.S. Constitution and the Federal Patient Self-Determination Act of 1990 (PL. 101-508) to indicate my wishes regarding mental health treatment. I understand that this directive will become active and take effect upon my incapacity to make my own mental health decisions and shall continue in effect only during that incapacity.

I intend that this document should be honored whether or not my agent dies or withdraws or if I have no agent appointed at the time of the execution of this document.

Incomplete sections in this Psychiatric 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 any part of this Psychiatric 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 Psychiatric Advance Directive stand alone. If some parts of this document are invalid or ineffective, I desire that all other parts be followed.

I intend this Psychiatric 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.

NOTE TO PROVIDER: The following page is a checklist of the sections I have completed. Failure to follow the instructions in these sections (or the requests of my agent), even in emergency situations, may result in legal liability for professional misconduct and/or battery. I include this statement to express my strong desire for you to acknowledge and abide by my rights, under state and federal laws, to influence decisions about the care I will receive.

Name: _____

Instructions Included in My Psychiatric Advance Directive
Put your initials in the space next to each section you have completed.

_____ Designation of my mental health care agent.

_____ Designation of alternate mental health care agent.

_____ Authority granted to my mental health care agent.

_____ When spouse is mental health care agent.

_____ Symptoms.

_____ When my plan is no longer needed.

_____ Clinicians.

_____ Medications.

_____ Hospitalization is not my first choice.

_____ Treatment facilities.

_____ Acceptable interventions.

_____ Preferred interventions.

_____ Help from others.

_____ Signature page.

_____ Record of Psychiatric Advance Directive.

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 mental health care agent to make certain decisions on my behalf regarding my mental health treatment when I do not have the capacity 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 decisions that my agent determines are the decisions I would make if I had the capacity to do so.

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. In the event that admission for psychiatric treatment is being considered, my agent must be notified/consulted before any decision is finalized

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)*_____
I certify that I do not, have not or will not provide care and treatment for this person.

Designation of Alternate Mental Health Care Agent
If the person named above is unavailable or unable to serve as my agent, I hereby appoint and desire immediate notification of my alternate agent as follows:

Name: _____

Address: _____

_____

Day Phone Number _____ Night Phone _____

Alternate Agent's Acceptance: I hereby accept the designation as alternate agent for

(Your name) _____

*(Your agent's signature)*_____
I certify that I do not, have not or will not provide care and treatment for this person.

Name: _____

The following paragraphs will apply when you appoint an agent.

Authority Granted to My Mental Health Care 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, mental health care treatment, mental health care provider, mental health care service or procedure, consistent with any instructions and/or limitations I have set forth in this Psychiatric Advance Directive. If I have not expressed a choice in this advance directive, I authorize my agent to make decisions that my agent determines are the decisions I would make if I had the capacity to do so.

B._____ If I choose to discharge or replace my agent, all other provisions of this Psychiatric Advance Directive shall remain in effect and shall only be revocable or changeable by me.

When Spouse Is Mental Health Care Agent and If There Has Been a Legal Separation, Annulment, or Dissolution of the Marriage
Initial if you agree with this statement; leave blank if you do not.

_____ I desire the person I have named as my agent, who is now my spouse, to remain as my agent even if we become legally separated or our marriage is dissolved.

Name: _____

The following sections outline when my Psychiatric Advance Directive should be activated, when it no longer needs to be used and details regarding my care, treatment and preferred interventions.

Symptoms
When I exhibit the following symptoms or behaviors, this would indicate that my Psychiatric Advance Directive needs to be enacted:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

When My Plan Is No Longer Needed
When I exhibit the following behaviors my plan no longer needs to be utilized:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Name: _____

Clinicians
The names of my doctors, therapists, pharmacists and service providers and their telephone numbers are:

Name	Phone #

I prefer treatment from the following clinicians:

Name

I refuse treatment from the following clinicians:

Name

Name: _____

Medications

I am currently using the following medications for:

_____
_____
_____
_____
_____
_____
_____
_____
_____

If additional medications become necessary, I prefer to take the following medications:

_____
_____
_____
_____
_____

I cannot tolerate the following medications because:

_____
_____
_____
_____
_____
_____

I am allergic to the following medications:

_____
_____
_____
_____
_____
_____
_____
_____

Name: _____

Hospitalization is not my first choice
This is my plan so I can stay at home or in the community.

_____
_____
_____
_____
_____
_____
_____
_____

Treatment Facilities
If it became necessary for me to be hospitalized I would prefer to be treated at the following facilities:

_____
_____
_____
_____

I do not wish to be treated at the following facilities:

_____
_____
_____
_____

• **Acceptable interventions:** *(Please place your initials in the blanks)*

Options:

Medication in pill form	Yes _____	No _____
Liquid medication	Yes _____	No _____
Medication by injection	Yes _____	No _____
Seclusion	Yes _____	No _____
Physical restraints	Yes _____	No _____
Seclusion and physical restraints	Yes _____	No _____
Experimental treatment	Yes _____	No _____
ECT	Yes _____	No _____

____ I consent to the administration of electroconvulsive therapy with the following conditions:

_____
_____
_____
_____

Name: _____

• Preferred interventions:

Help from Others

List your supporters and the ways they can help you. Be sure to write their names, phone numbers and responsibilities (mail, bills, pet, child care, etc.).

Name	**Phone Number**	**Responsibility**

Name: _____

I developed this Psychiatric Advance Directive on (date) _____

Any plan with a more recent date supersedes this one.

Signed _____ Date _____

Witness _____ Date _____

Witness _____ Date _____

(for use by the notary)

STATE OF _____, County of_____

Subscribed and sworn to or affirmed before me by the Principal,

_____,

and (names of witnesses)

_____ and

_____,

witnesses, as the voluntary act and deed of the Principal, this _____ day of_____. _____.

My commission expires:

_____

_____
Notary Public

Name: _____

Record of Psychiatric Advance Directive

I have given copies of my Psychiatric Advance Directive to:

Name/Location: _____
Address: _____
Phone Numbers: _____

Name/Location: _____
Address: _____
Phone Numbers: _____

Name/Location: _____
Address: _____
Phone Numbers: _____

Name/Location: _____
Address: _____
Phone Numbers: _____

Name/Location: _____
Address: _____
Phone Numbers: _____

Name/Location: _____
Address: _____
Phone Numbers: _____

Name/Location: _____
Address: _____
Phone Numbers: _____

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