HEALTH CARE DIRECTIVE

Under the Uniform Health Care Decisions Act
18-A M.R.S.A. § 5-801 et seq.

I, _____ currently of_____, _____,
name street address city

Maine, whose birth date is _____, execute this Health Care Directive so that I might obtain mental health care and treatment.

(1) THESE INSTRUCTIONS BECOME EFFECTIVE WHEN: (*Indicate the applicable options*)

____ my primary physician, or, if I should be in an emergency room or in a treatment setting, the attending physician determines that I am unable to make my own health-care decisions.

_____ my primary physician, or, if I should be in an emergency room or in a treatment setting, the attending physician determines that I meet involuntary hospitalization standards.

_____ my primary physician, or, if I should be in an emergency room or in a treatment setting, the attending physician determines that if I do not receive psychiatric hospitalization or the treatment as set out in this instrument my condition will quickly deteriorate such that I would soon meet the standard for involuntary hospitalization.

_____ other. Describe _____

_____

_____

The above option(s) require a second physician's opinion. Yes._____ No _____

I waive the 2nd opinion requirement if another physician is not available. Yes _____ No _____

(If I require a second opinion and do not waive the requirement should no second physician be available, I understand that my advance directive may not become effective.)

(2) NOMINATION OF GUARDIAN: *(OPTIONAL)* If a guardian of my person needs to be appointed for me by a court, I nominate the following individual to be appointed as my guardian.

_____

(name of individual) (home phone) (work phone)

_____

(address)

_____

(city) (state) (zip code)

PART I INSTRUCTIONS FOR HEALTH CARE

I request that I be provided the following treatment:

I. 24 hour care

Alternatives to hospitalization

In the event my condition becomes serious enough that I am found to need 24 hour care, I prefer to avoid hospitalization as possible, and request that the following services be explored first.

_____ Crisis respite services. I prefer to receive services at the following agencies:

_____

_____

names of agencies if you have preferences

____ In-home crisis services. I prefer to receive servies at the following agencies:

_____

_____

names of agencies if you have preferences

——— Other services (describe)

_____

_____

My reasons for wanting these services as alternatives to hospitalization are as follows:

(optional, but recommended)_____

_____

_____

_____

Psychiatric Hospitalization

In the event that psychiatric hospitalization is the only suitable alternative, I direct that it be sought at the following hospitals in the following order of priority:

_____
name of hospital

_____
name of hospital

_____
name of hospital

_____
name of hospital

This directive may operate as my informed consent to admission as a voluntary patient to the above listed hospitals.

This consent shall operate even if I pose any verbal objections at the time. Yes_____ No _____

If none of the above hospitals have available beds, this directive may operate as my informed consent to admission to any other hospital as follows: *(Select applicable option)*

_____ To any other hospital, provided I do not object at the time.

_____ To any other hospital, even if I am objecting at the time, *except for the following listed hospitals.*

_____
name of hospital to which my consent is *not* given

_____

name of hospital to which my consent is *not* given

_____

name of hospital to which my consent is *not* given

My reasons for wanting these psychiatric hospitalization options are as follows:

(optional, but recommended)_____

_____

_____

_____

If I need to be transported to a psychiatric hospital as an involuntary patient, I request that I be transported by the following means:

_____ Ambulance

_____ Sheriff or police vehicle. (I understand that by requesting this service I am waiving any claims or rights I may have under law to be transported in a medically equipped vehicle in the company of emergency medical technicians or other medically trained personnel.)

Other notes regarding transportation and my reasons for requesting transportation by this

means are as follows:

_____

_____

II. Medications

I consent, and my agent is authorized to consent to the administration of medications as follows. *(select options*)

Medication	Dosage Limits, if any	Only Orally If checked
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

____ All medications as prescribed by my primary physician, except as may be limited below.

_____ All medications as authorized by my agent except as may be limited below.

_____ I do not authorize and my agent may not consent to the following medications.

Medication:_____

_____

_____

_____

My reasons for not consenting to the above medications is as follows: (optional but recommended)

_____

_____

_____

_____ If any action can be taken to eliminate my above stated concerns regarding the excluded medications, my agent is authorized to consent to their administration provided such additional action is taken to accommodate my stated concerns.

_____ Other instructions with regard to medications:

_____

_____

_____

_____

_____

_____

III. Emergency Interventions while in a hospital

I understand that while I am in a psychiatric facility certain interventions may be authorized in an emergency should my behavior be imminently dangerous to myself or others.

I believe such an emergency can be avoided if I am treated in the following way: _____

_____

_____

_____

_____

If an emergency nevertheless arises, I prefer emergency interventions be implemented as follows: (State preferences with regard to the use of seclusion, restraint, offer of oral medications, medications by injection.)

_____

_____

_____

III. Other treatment while in a hospital

I have responded favorably to the following treatment in a hospital setting, and request that these treatment options be offered.

Describe treatment options (family therapy, for example)

_____

_____

_____

IV. Electroconvulsive Therapy (ECT)

____ I do not consent and my agent is not authorized to consent to the administration of ECT.

_____ I consent to the administration of ECT as prescribed by my primary physician, except as
may be limited below.

____ I consent to the administration of ECT as authorized by my agent, except as may be
limited below.

_____ Limitations upon consent to the administration of ECT:

_____ My consent is limited to _____ number of treatments.

_____ Consent may not be sought from my agent until s/he has had _____ days to consider the risks and benefits of the treatment.

_____ My consent is otherwise limited as follows:

_____

_____

_____

My reasons for consenting or refusing ECT as set out above, is as follows: (optional, but recommended)_____

_____

V. Notices

If I am admitted to a facility, I request that the following individuals be notified immediately.

_____ _____
(name of individual) (home phone) (work phone)

_____
(address)

_____
(city) (state) (zip code)

_____ _____
(name of individual) (home phone) (work phone)

_____
(address)

_____
(city) (state) (zip code)

VI. Child Care Arrangements If I am to be admitted to residential care or to a hospital, or I am otherwise unable to care for my children, and I have not made prior child care arrangements, I authorize my agent to make those arrangements. If my agent or alternative is not available, I request that the following individual be contacted to care for my children temporarily:

_____ _____
(name of individual) (home phone) (work phone)

_____
(address)

_____
(city) (state) (zip code)

VI. Other Instructions

_____

_____

_____

_____

_____

PART 2 PRIMARY PHYSICIAN

I designate the following as my primary physician, for the purposes of this directive:

_____ _____
(name of physician) (phone number)

_____
(address)

_____
(address)

_____
(city) (state) (zip code)

A COPY OF THIS FORM HAS THE SAME EFFECT AS THE ORIGINAL.

_____ Dated: _____
signature

_____ _____
witness signature witness signature

_____ _____
witness Address witness address

_____ _____
city state zip code city state zip code

Dated:_____Dated:_____