PSYCHIATRIC ADVANCE DIRECTIVE

TO MY FAMILY, MY PHYSICIAN, MY LAWYER
AND ALL OTHERS WHOM IT MAY CONCERN

Declaration made this ____ day of, _____ 20 _____.
I, being of sound mind, willfully and voluntarily make known my desires for mental health treatment(s) to be followed should it be determined by two physicians, one of whom is my attending physician, that my ability to receive and evaluate information effectively or communicate decision is impaired to such an extent that I lack the capacity to refuse or consent to mental health treatment. I understand that any treatment(s) would be toward the goal of psychiatric restabilization as a way of restoring my capacity and optimal mental health functioning. I further understand that psychiatric restabilization may include administration of prescribed liquid medication by mouth or injection, administration of prescribed medication orally, physical restrain, seclusion or crisis psychiatric counseling and that in the statements below I may give or refuse consent to any of these or other treatment options to which I stipulate.

DIRECTIVE DURATION AND REVOCATION UNDERSTANDINGS

I understand this declaration expires two years after it becomes effective, unless extended by me in writing.

I understand that I may revoke this declaration at any time unless I have been declared to lack capacity to give or withhold treatment by two physicians, one of whom is my attending physician.

UNDERSTANDING ABOUT WHEN OR WHY THIS DIRECTIVE MAY BE PUT INTO EFFECT

I understand that I may become incapable of giving or withholding informed consent for mental health treatment due to symptoms of a diagnosed mental disorder. The symptoms may include the following:

_____

_____

_____

_____

MY DECLARATIONS ABOUT MEDICATIONS for PSYCHIATRIC TREATMENT

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding medications are as follows:

_____ I consent to the administration of medications.

_____ I consent to the administration of the following medications:

_____

_____

_____ I do not give consent to the administration of medications.

_____ I do not give consent to the administration of the following medications:

_____

_____

Conditions or limitations:

_____

_____

_____

MY DECLARATIONS ABOUT PHYSICAL RESTRAINTS, SECLUSION, AND CRISIS INTERVENTIONS

Should I become incapable of giving or withholding informed consent for mental health treatment due to the symptoms of a diagnosed mental disorder and my behaviors become dangerous to myself or others, or should I become incapable of providing for my basic need. In this case I would give consent for the following safety measures or treatment(s):

_____ Physical Restraint _____ Seclusion _____ Crisis Psychiatric Counseling

Other Interventions I prefer/conditions/limitations/concerns:

_____

_____

_____

I would NOT give consent for:

_____Physical Restraint _____ Seclusion _____ Crisis Psychiatric Counseling

Why or why not or concerns:

_____

_____

_____

NAME OF TREATMENT PROVIDERS WITH WHOM I AM NOW INVOLVED

_____ _____

Name of Provider/Institution | Telephone Number of Provider/Institution

_____

_____

Name, Address, and Telephone Number of Attending Physician/Psychiatrist

TREATMENT FACILITY PREFERENCES

I prefer the following facilities to be used for emergency or stabilization purposes:

_____

_____

_____

NOTIFICATION PREFERENCES

I would like the following persons notified if it is deemed necessary to put this directive into effect:

_____

_____

_____

I specifically request the following persons/entities not be notified:

_____

_____

VISITOR PREFERENCES

I prefer to have the following persons be allowed to visit me during a time of re-stabilization:

_____

_____

_____

I specifically request the following persons NOT be allowed to visit me during a time of re-stabilization:

_____

_____

_____

CHILD CARE PREFERENCES

I request the following persons be considered in arranging child care necessary during times of re-stabilization:

_____

_____

I specifically request the following persons NOT be used for child care for my children:

_____

_____

_____

PROPERTY AND/OR PET CARE PREFERENCES

I request the following persons be considered in arranging for the care of my property or pets during times of re-stabilization:

_____

_____

_____

I specifically request the following persons not be considered in arranging for the care of my property or pets:

_____

_____

_____

OTHER DECLARATIONS OR PREFERENCES FOR MY RE-STABILIZATION:

_____

_____

_____

Please complete the following information to assist your physician and other psychiatric personnel to rapidly identify you as the declarant of this Psychiatric Advance Directive:

Date of Birth _____ Sex _____

Eye Color _____ Hair Color _____

Racial or Ethnic Background _____

Social Security Number_____

Copies of this document are in the following places (ie., family members, doctors office, hospitals, mental health centers.....)

_____

_____

MENTAL HEALTH PROFESSIONAL STATEMENT REGARDING CAPACITY

It is my professional opinion at this time that this person has the capacity to make this directive:
_____ Yes _____ No

_____ _____
Signature of Psychiatrist/Mental Health Professional Date

APPOINTMENT OF AN AGENT FOR MENTAL HEALTH CARE AND TREATMENT

_____ (check and initial) I do not want an agent acting on my behalf

Should I become incapable of giving or withholding informed consent for mental health treatment due to the symptoms of a diagnosed mental disorder I hereby appoint:

Name_____

Address_____

Telephone Number(s)_____

to act as my agent in making decision regarding my mental health treatment. I understand that this person will gain this appointment only if I am declared to lack capacity by two physicians, one of who will be my immediate physician.
My agent is authorized to make decision that are consistent with the wishes I have expressed in this declaration, or, if not expressed, as are otherwise known to my agent. If my wishes are not expressed and are not otherwise known by my agent, that person is to act in what he or she believes to be in my best interest.

ACCEPTANCE OF APPOINTMENT AS AGENT

I accept this appointment and agree to serve as the agent to make decisions about mental health treatment for, _____. I understand I have a duty to act consistent with the desires of this individual as expressed in this appointment. I understand this document gives me the authority to make decisions about mental health treatment only while this person is incapable as determined by a court or two physicians. I understand that he/she may revoke this declaration in whole or in part at any time and in any manner when he or she has capacity to make decisions.

_____ _____
Signed Date

_____
Address

_____
City, County, and State of Residence

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 our names below as witnesses. 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_____.
(day) (month) (year)

WITNESS SIGNATURES:

Witness Number One (print) _____

Signature of Witness No. 1 _____

Home Address of Witness No. 1 _____

_____
City State ZIP

Witness Number Two (print) _____

Signature of Witness No. 2 _____

Home Address of Witness No. 2 _____

_____
City State ZIP