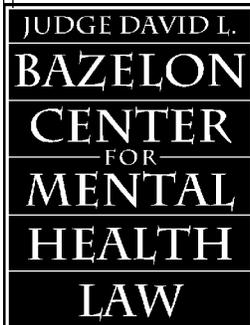


PSYCHIATRIC ADVANCE DIRECTIVE

Forms to Prepare
an Advance Directive
for Mental Health
Decisionmaking



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Additional copies of this booklet may be obtained from the publications desk at the Bazelon Center (send a self-addressed 9"x 12" envelope stamped with \$1.06 postage). The forms are also available to print or download from www.bazelon.org/issues/advancedirectives/index.htm.

The Bazelon Center for Mental Health Law works to protect and advance the civil and legal rights of adults and children with mental illnesses or developmental disabilities and ensure their equal access to the services and supports they need for full participation in community life. The center conducts test-case litigation and policy analysis, builds coalitions, provides technical support to state advocates, issues action alerts, publishes handbooks and maintains extensive advocacy resources on its website.



Advance Psychiatric Directives

If you are concerned that you may be subject to involuntary psychiatric commitment or treatment at some future time, you can prepare a legal document in advance to express your choices about treatment. The document is called an advance directive for mental health decisionmaking.

Here we offer a set of templates you can use to prepare such a directive. You can use them to:

- tell a doctor, institution or judge what types of confinement and treatment you do or do not want; and/or
- appoint a friend or family member as “agent” to make mental health care decisions for you if you are incapable of making them yourself.

What are the advantages of a psychiatric advance directive?

If you expect to need mental health treatment in the future and believe that you might be found incompetent to make your decisions at that time:

- An advance directive empowers you to make your treatment preferences known.
- An advance directive will improve communication between you and your physician. It can prevent clashes with professionals over treatment and may prevent forced treatment.
- Having an advance directive may shorten your hospital stay.

Will my psychiatric advance directive be legally binding?

While advance directives for health care have been around a long time, their use for psychiatric care is a very new area of law. *We do not yet know how courts will deal with them, especially when safety issues arise.* State laws vary and it is possible that part or all of this document will not be effective in your state. However, many mental health consumers who are now using these documents find that an advance directive increases the likelihood that doctors, hospitals and judges honor their choices.

Please note that these template forms do not constitute legal advice. Before you assume that the advance directive you create using any or all of these forms will be legally valid in your state, you should consult a lawyer.

Where can I get legal advice about advance directives in my state?

Your state Protection and Advocacy System (P&A) may be able to tell you about your state’s requirements or refer you to a lawyer who can. For the name and number of the system in your state, visit the website of the National Association of Protection and Advocacy Systems, www.protectionandadvocacy.com, or call NAPAS at 202-408-9514. The Bazelon Center is *not* able to respond to individual inquiries.

Do I have to appoint an agent?

That depends on the law in your state. In some states, you may set up an advance directive without appointing a person to act for you. In most states, however, an advance directive for psychiatric care is only valid if you have named an agent. The Bazelon Center's study of advance directives suggests that these tools are much more likely to be honored by providers when an agent has been appointed. We strongly urge consumers to name an agent whenever possible.

If you appoint an agent, it should be someone you trust. You can direct your agent to present the choices you have expressed in your advance directive. You can also authorize him or her to make other decisions about your care that are not in your directive. Or you can appoint an agent without giving any written instructions, but if you do this, you should clearly explain what your wishes are so he or she can advocate effectively on your behalf.

The template includes a provision (item 5 in Section II) that your agent's decisions about mental health treatment would prevail even if a court appoints a guardian or conservator for you.

Does the document cover health care too?

No. The document you produce with these template forms will be an advance directive for mental health decisionmaking only; it will not cover decisions about other medical or surgical treatment. It is a good idea to have an advance directive for health care as well, stating your preferences about emergency medical treatment. Forms to create one are available from most hospitals and health agencies. A form for New York State can be downloaded.

How do I use the forms?

We created the advance directive as six separate template forms rather than one, in part because it was originally designed for the WorldWide Web and is easier to print or download as a series of smaller "pages." Furthermore, the separation makes the document more flexible.

The only required sections are I, your statement of intent, and VI, the signature page—and in states that require an agent, II, the appointment of an agent. The other three templates are optional, though without at least one, you wouldn't have a directive. You may use them to express your preferences about hospitalization and treatment (III), about notification and visitors if you are admitted to a psychiatric facility (IV) and about the circumstances under which you can suspend the directive (V).

When we asked mental health consumers to test the templates, it took them between 45 and 75 minutes to complete all six sections. Completing these forms is likely to take you under two hours.

If you are reading this on paper, go to the section, Directions for Using the Forms, then make a copy of each form you wish to use.

If you prefer, go online and print this overview for your future reference. Then click on the links for the sections on the list of templates and print or download each one you wish to use.

- It's easy to print the various forms and complete them with a pen. While each document is on your screen, use the "print" button on your browser.
- If you prefer to edit the forms on a computer, you can download them with the "save as.." command on your browser's "File" menu. The text will be in ASCII format, with codes in the web language called HTML. You can edit it in Microsoft Word or WordPerfect, or if you have an HTML editor like Macromedia Dreamweaver or Microsoft Frontpage, you can use this text to edit the forms so they will look much as they did on the internet.

Additional information is available through the Bazelon Center's website.

On the website version of this page, www.bazelon.org/issues/advancedirectives/index.htm, you will find links to a number of materials.

- an analysis of state statutes relating to advance directives for mental health care, see *Advance Directive for Mental Health Care: An Analysis of State Statutes*, an article by Robert D. Fleishner, and a bibliography of cases and materials on advance directives for people with mental illnesses, both available on www.napas.org;
- two articles on Advance Directives on the National Empowerment Center website, www.power2u/selfhelp: "Making Advance Directives Work for You," by Daniel Fisher, M.D., Ph.D. and "Advance Directives Are What You Make Them," by Xenia Williams;
- state-specific materials from California, New York, North Carolina, Ohio, Oregon, Texas and West Virginia.

Contents

A. Directions for Using the Forms

Part I

A statement of your intent in creating an advance directive for mental health care decisionmaking. This emphasizes your strong desire that providers respect your right to influence all decisions about the your care.

Part II

This form lets you name another person to make decisions for you if you are determined to be legally incompetent to make your own choices. Also, your instructions about the circumstances under which you can change your agent and who should be appointed your guardian if a court decides to name one.

Part III

Your instructions about hospitalization and alternatives to hospitalization, medications, electroconvulsive therapy (ECT), emergency interventions (including seclusion, restraint and medication) and experimental studies or drug trials.

Part IV

Your instructions about who should be notified immediately if you are admitted to a psychiatric facility, who should be prohibited from visiting you and who should have temporary custody of your child(ren).

Part V

Here you may choose whether or not you will have the right to suspend or terminate your advance directive while you are incapacitated, if allowed by the law in your state. The section includes space for any other instructions about mental health care.

Part VI

Signature page, on which you and two witnesses sign the advance directive before a notary, after you have filled in the blanks and made any changes you wish.

As explained above, the Bazelon Center doesn't have the capacity to answer individual questions about the advance directive and its use. For this, you need to contact your state protection and advocacy system. However, we welcome your comments and any suggestions for improving these forms. You can e-mail comments to ellenh@bazelon.org.

Psychiatric Advance Directive

A. Directions for Using the Forms

How to Fill Out the Forms

1. Read each section carefully.
2. Choose which sections you wish to use. Sections I and VI are required. If you aren't sure whether or not you want to use section II, appointing an agent, find out if your state's law requires an agent for mental health decisionmaking. Your state protection and advocacy agency may be able to tell you. Sections III, IV and V are optional and cover the substance of your instructions.
3. If you decide to appoint an agent—and we encourage you to do so—make sure he or she understands your wishes and is willing to take the responsibility. Your agent and alternate agent(s) should sign the form to show acceptance of the responsibility.
4. Talk over your choices with your treating providers and your case manager.
5. Fill in only the choices you want in sections III, IV and V. Your advance directive should be valid for whatever part(s) you fill in, as long as it's properly signed. You may cross out and/or write in words or sentences (or rewrite, if you are editing the document on a computer).
6. To indicate which choices you want, put your initials in the blank at the beginning of a statement. If you do not want a statement to be true, leave the blank empty.
7. Add any special instructions in the spaces provided. Be sure you also put your initials in the blank at the beginning of that segment to make your choices valid. You can write additional instructions or comments on a separate sheet of paper, but be sure to write on the form that there are additional pages.
8. Complete the checklist attached to section I to show at a glance what your advance directive covers.
9. Assemble the completed sections, renumber the pages and sign section VI before two witnesses (see the list on the signature page of people who cannot be your witness). Some states may require a notary's signature as well; if you are not sure, it's best to have the document notarized.
10. Have copies made and give them to your doctor(s), the individual(s) you have appointed to make mental health care decisions for you, your family and anyone else who might be involved in your care. Explain your choices to each of them.

Can I change my mind?

You can revise your advance directive at any time unless you have been declared legally incompetent. However, state laws vary about whether you may revoke your advance directive or overrule your own agent after becoming incapacitated. Part V spells out some options describing when you want to be able to revoke, suspend or end this advance directive. A lawyer can explain your state's law in this regard. (Note that only a few states have any specific law on this. As of 2001, Alaska, Hawaii, Idaho, Illinois, Maine, Minnesota, North Carolina, Oklahoma, Oregon, South Dakota, Texas, Utah, West Virginia and Wyoming do.)

Should I see a mental health professional before signing an advance directive?

For your advance directive to be valid, you must be legally competent when you sign it. To protect yourself against any claim that you were not competent when you signed your advance directive, you can ask a mental health professional to conduct a mental status exam and note in your medical record file that you were of sound mind at the time. Ask for a signed copy of this note, and attach it to your advance directive. This is not absolutely necessary, but it can head off future challenges.

What to do when you are finished

You want your advance directive to be an active part of your medical record. It is a good idea to discuss your choices with your case manager and treating providers. Your advance directive is more likely to be remembered and followed if you have told them about it and explained to them the choices you made, and why.

When will my advance directive take effect?

Your advance directive will become active, under most states' laws, when a doctor, usually your treating physician, determines that you are not capable of making health care decisions on your own behalf.

Who should have copies?

Your treating professionals should have copies of your advance directive. Your agent, if you appoint one, and each alternate agent you name should have a copy. Also consider giving copies to family members, close friends, the hospitals or programs where you might be taken in an emergency, your managed care firm (if you have one) and your other service providers. If you make changes, be sure to let everyone who has a copy know. For this reason, you'll want to keep track of who has copies; a form for doing this is attached to the signature page.

If you travel, be sure to take a copy with you. And keep the original in an easily accessible place.

How will anyone know I have an advance directive?

A form that advises physicians and others of your advance directive appears below. It is designed to fit in your wallet. Complete the information on the form, cut it out, fold it in half and keep it in your wallet.

PHYSICIANS AND OTHERS PLEASE NOTE:

I have an advance directive for mental health decisionmaking, a legal document stating my preferences as to psychiatric hospitalization and treatment. A copy may be found at: _____

If I am incapacitated, please obtain this document and respect the choices I have registered in it.

My name: _____ My SS#: _____

I have appointed as my agent for mental health decisionmaking _____ who can be reached at _____ (day) or _____ (evening). This person is authorized to make all decisions about my psychiatric treatment in the event that I am incapable of making such decisions.

PART I

STATEMENT OF INTENT

I, (your name), being of sound mind, willfully and voluntarily execute this 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. In the event that a guardian or other decisionmaker 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. 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.

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 the 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 other decisionmaker.

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.

NOTE TO PROVIDER: The next 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.

Instructions Included in My Directive

Put a checkmark in the box next to each section you have completed.

- Designation of my health care agent(s).
- Authority granted to my agent.
- My preference as to a court-appointed guardian.
- My preferences about no termination in the event a guardian or other agent is appointed.
- My choice of treatment facility and preferences for alternatives to hospitalization if 24-hour care is deemed medically necessary for my safety and well-being.
- My preferences about the physicians who will treat me if I am hospitalized.
- My preferences regarding medications for psychiatric treatment.
- My preferences regarding electroconvulsive therapy (ECT or shock treatment).
- My preferences regarding emergency interventions (seclusion, restraint, medications).
- Consent for experimental studies or drug trials.
- Who should be notified immediately of my admission to a psychiatric facility.
- Who should be prohibited from visiting me.
- My preferences for care and temporary custody of my children.
- My preferences about revocation of my health care directive during a period of incapacity.
- Other instructions about mental health care.
- Duration of this mental health care directive.

Go to Part II of the Advance Directive.

Advance Directive of _____ for Mental Health Care Decisionmaking
(your name)

PART II

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.

Note: Make sure to list this person in Part IV of your advance directive.

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) _____

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:

Note: Make sure to list this person in Part IV of your advance directive.

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) _____

The following paragraphs will apply when you appoint an agent.

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 revokable or changeable by me at a time when I am considered competent and capable of making informed health care decisions.

3. When Spouse Is 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.

4. My Preference as to a Court-Appointed Guardian

In the event a court decides to appoint a guardian who will make decisions regarding my mental health treatment, I desire the following person to be appointed:

Name: _____ Relationship: _____

Address: _____

City, State, Zip Code: _____

Day phone: _____ Evening Phone: _____

5. Powers of a Guardian

The appointment of a guardian of my estate or my person or any other decisionmaker shall not give the guardian or decisionmaker the power to revoke, suspend, or terminate this directive or the powers of my agent, except as specifically required by law.

BE SURE TO GIVE YOUR AGENT AND ALTERNATE AGENT A COPY OF ALL SECTIONS OF THIS DOCUMENT

Go to Part III of the Advance Directive.

PART III

STATEMENT OF MY DESIRES, INSTRUCTIONS, SPECIAL PROVISIONS AND LIMITATIONS REGARDING MY MENTAL HEALTH TREATMENT AND CARE

In this part, you state how you wish to be treated (such as which hospital you wish to be taken to, which medications you prefer) if you become incapacitated or unable to express your own wishes. If you want a paragraph to apply, put your initials after the paragraph letter. If you do not want the paragraph to apply to you, leave the line blank.

1. My Choice of Treatment Facility and Preferences for Alternatives to Hospitalization If 24-Hour Care Is Deemed Medically Necessary for My Safety and Well-Being

A. ____ In the event my psychiatric condition is serious enough to require 24-hour care and I have no physical conditions that require immediate access to emergency medical care, I would prefer to receive this care in programs/facilities designed as alternatives to psychiatric hospitalizations.

A1. ____ I would prefer to receive 24-hour care at the following programs/facilities:

B. ____ In the event I am to be admitted to a hospital for 24-hour care, I would prefer to receive care at the following hospitals:

C. ____ I do *not* wish to be committed to the following hospitals or programs/facilities for psychiatric care for the reasons I have listed:

Facility's Name: _____

Reason: _____

Facility's Name: _____

Reason: _____

Facility's Name: _____

Reason: _____

2. My Preferences Regarding Emergency Interventions

If, during an admission or commitment to a mental health treatment facility, it is determined that I am engaging in behavior that requires an emergency intervention (e.g., seclusion and/or physical restraint and/or medication), my wishes regarding which form of emergency interventions should be made are as follows. I prefer these interventions in the following order:

Fill in numbers, giving 1 to your first choice, 2 to your second, and so on until each has a number. If an intervention you prefer is not listed, write it in after "other" and give it a number as well.

	Reasons for my preferences:
___ seclusion	_____
___ physical restraints	_____
___ seclusion and physical restraint (combined)	_____
___ medication by injection	_____
___ medication in pill form	_____
___ liquid medication	_____
___ other: _____	_____

Initial this paragraph if you agree; leave blank if you do not agree.

_____ In the event that my attending physician decides to use medication for rapid tranquilization in response to an emergency situation after due consideration of my preferences for emergency treatments stated above, I expect the choice of medication to reflect any preferences I have expressed in this section and in Section 3. The preferences I express in this section regarding medication in emergency situations do not constitute consent to use of the medication for non-emergency treatment.

3. My Preferences About the Physicians Who Will Treat Me if I Am Hospitalized.

Put your initials after the letter and complete if you wish either or both paragraphs to apply.

A. _____ My choice of treating physician is:	B. _____ I do <i>not</i> wish to be treated by the
Dr. _____	following, for the reasons stated:
Phone number _____	Dr. _____
OR	Reason: _____
Dr. _____	_____
Phone number _____	_____
OR	Dr. _____
Dr. _____	Reason: _____
Phone number _____	_____

4. 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:

Medication Name	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:

5. My Preferences Regarding Electroconvulsive Therapy (ECT or Shock Treatment)

If it is determined that I am not legally capable of consenting to or refusing electroconvulsive therapy, my wishes regarding electroconvulsive therapy are as follows:

Initial A or B; if you mark B, you must also initial B1, B2 or B3:

A. ____ I do *not* consent to administration of electroconvulsive therapy.

B. ____ I consent, and authorize my agent to consent, to the administration of electroconvulsive therapy, but only:

B1. ____ with the number of treatments that the attending psychiatrist deems appropriate;

OR

B2. ____ with the number of treatments that Dr. _____ deems appropriate. Phone number and address of doctor:

OR

B3. ____ for no more than the following number of ECT treatments: _____

C. ____ Other instructions and wishes regarding the administration of electroconvulsive therapy:

6. Consent for Experimental Studies or Drug Trials

Initial one of the following paragraphs.

A. ____ I do *not* wish to participate in experimental drug studies or drug trials.

B. ____ I hereby consent to my participation in experimental drug studies or drug trials.

C. ____ I authorize my agent to consent to my participation in experimental drug studies if my agent, after consultation with my treating physician and any other individuals my agent may think appropriate, determines that the potential benefits to me outweigh the possible risks of my participation and that other, non-experimental interventions are not likely to provide effective treatment.

Go to Part IV of the Advance Directive.

PART IV

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: _____
Address: _____

Phone (Day): _____
Phone (Eve.): _____
It is also my desire that this person be permitted to visit me: Yes ___ No ___

Name: _____
Relationship: _____
Address: _____

Phone (Day): _____
Phone (Eve.): _____
It is also my desire that this person be permitted to visit me: Yes ___ No ___

Name: _____
Relationship: _____
Address: _____

Phone (Day): _____
Phone (Eve.): _____
It is also my desire that this person be permitted to visit me: Yes ___ No ___

Name: _____
Relationship: _____
Address: _____

Phone (Day): _____
Phone (Eve.): _____
It is also my desire that this person be permitted to visit me: Yes ___ No ___

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 & Temporary Custody of My Children

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

Name: _____ Relationship: _____

Address: _____

City, State, Zip: _____

Phone number: (Day) _____ (Evening) _____

In the event that the person named above is unable to care for and have temporary custody of my child(ren), I desire one of the following people to serve in that capacity.

My Second Choice:

Name: _____ Relationship: _____

Address: _____

City, State, Zip: _____

Phone number: (Day) _____ (Evening) _____

My Third Choice:

Name: _____ Relationship: _____

Address: _____

City, State, Zip: _____

Phone number: (Day) _____ (Evening) _____

Go to Part V of the Advance Directive.

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.

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.

Go to signature page.

Advance Directive of _____ for Mental Health Care Decisionmaking
(your name)

PART VI 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 SIGNATURES:

Witness 1:

Signature of Witness 1

Name of Witness 1 (printed)

Home address of Witness 1

City, State, Zip Code of Witness 1

Witness 2:

Signature of Witness 2

Name of Witness 2 (printed)

Home address of Witness 2

City, State, Zip Code of Witness 2

(for use by the notary):

STATE OF _____, County of _____

Subscribed and sworn to or affirmed before me by the Declarant, _____

_____, and (names of witnesses) _____

and _____, witnesses, as the voluntary act

and deed of the Declarant, this _____ day of _____, 20__.

My commission expires: _____

Notary Public

RECORD OF PSYCHIATRIC ADVANCE DIRECTIVE

Keep this form and give a copy to your agent, if you have appointed one.

_____ My name
_____ My health care agent's name

_____ My address
_____ My health care agent's address

_____ My date of birth

_____ My health care agent's telephone number(s)

I have given copies of my psychiatric advance directive to:

_____ Name
_____ Address or phone

NOTES

