ADVANCE DIRECTIVE FOR MENTAL HEALTH TREATMENT

Statement of Intent

I, _____, being an adult of sound mind, willfully and voluntarily complete this Psychiatric Advance Directive to ensure that, during periods in which I lack the capacity to make an informed decision about my mental health care, as certified in writing by two physicians, my choices regarding mental health care shall be carried out. It is my intent that my wishes expressed in this document be honored whether or not my agent dies or withdraws or if I have no agent appointed at the time this document is signed. In the event that a guardian or other decision maker is appointed by a court to make health care decisions for me, I intend that this document take priority over all other means of discovering my intent while competent.

The fact that I may have not completed certain sections of this Advance Directive should not affect its validity in any way. I intend that all completed sections be followed. If I have not expressed a choice, any agent or other decision-maker designated under this Advance Directive or by law should make the decision that he or she determines is the decision I would make if I were competent to do so.

It is my intention that each part of this Advance Directive stands alone and, therefore, if any part is invalid or ineffective, it does not affect the validity or effectiveness of any other part.

I further intend that this mental health Advance Directive take precedence over any and all living will documents and/or durable power of attorney for health care documents and/or other Advance Directives that I have previously executed, to the extent that they are inconsistent with this document.

SECTION I. INSTRUCTIONS REGARDING MENTAL HEALTH TREATMENT

[Place your initials in the box next to your choices and provide information where appropriate.]

A. Medications for mental health treatment (including medications to control side effects).

1. _____ ☐ - I consent to and authorize my agent to consent to the administration of the following medications and dosages:

Medication Name	Not to exceed the following dosage :
_____	_____
_____	_____
_____	_____
_____	_____

2. _____ ☐ - I consent to the medications and dosages deemed appropriate by

Dr. _____ whose address and phone number are:

_____
Address

_____
Phone

3. _____ ☐ **-** 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 restrictions, if any, described in 4 & 5 below.

4. _____ ☐ **-** 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 incidence (check all that apply):

☐ - Tardive dyskinesia ☐ - Seizures Tremors ☐ - Loss of sensation ☐ - Nausea/vomiting
☐ - Motor restlessness ☐ - Muscle/skeletal rigidity ☐ - Neuroleptic Malignant Syndrome

☐ **-** Other _____

5. _____ ☐ - 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
_____	_____
_____	_____
_____	_____
_____	_____

B. Electroconvulsive Therapy (ECT)

1. _____ ☐ - I do not consent to administration of ECT;

OR

2. _____ ☐ - I consent, and authorize my agent to consent, to administration of ECT,

but only:

a. ☐ **-** with the number of treatments the attending psychiatrist deems appropriate;

OR

b. ☐ - with the number of treatments deemed appropriate

by

Dr. _____whose phone number and address are:

_____

Address

_____

Phone

OR

c. ☐ - for no more than the following number of treatments:

_____

3. _____ ☐ **-** Other instructions and wishes regarding the administration of ECT:

_____

_____

_____

_____

_____

C. Transcranial Magnetic Stimulation (TMS)

1. _____ ☐ - I do not consent to administration of TMS;

OR

2. _____ ☐ **-** I consent, and authorize my agent to consent, to administration of TMS, but only:

a. ☐ **-** with the number of treatments the attending psychiatrist deems appropriate;

OR

b. ☐ **-** with the number of treatments deemed appropriate by Dr. _____whose phone number and address are:

_____
Address

_____
Phone

OR

c. ☐ - for no more than the following number of treatments: _____

3. _____ ☐ - Other instructions and wishes regarding the administration of TMS:

_____

_____

_____

_____

_____

D. Other forms of mental health treatment (e.g., individual psychotherapy, group therapy, self-help services, body-oriented treatments, etc.):

1. _____ ☐ - I consent to the following types of mental health treatment:

_____

_____

_____

2**. _____** ☐ **-** I do not consent to following types of mental health treatment:

_____

_____

_____

E. Choice of hospital, facility, program and treating professional(s)

1. **_____** ☐ **- I** In the event that my mental health 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 a program/facility designed as an alternative to a psychiatric hospital.

2. _____ ☐ - I In the event that I am to be admitted to a hospital for mental health treatment, I would prefer to receive care at the following hospitals:

   _____

   _____

3. _____ ☐ **-** I do not wish to be admitted/committed to the following hospitals or programs/facilities for mental health care for the reasons I have listed:

Hospital/Program/Facility	Reason
_____	_____
_____	_____
_____	_____
_____	_____

4. _____ ☐ - I do not wish to receive care/services from the following mental health professionals:

Physician/Other Professional	Reason
_____	_____
_____	_____
_____	_____

F. Experimental Studies or Drug Trials

1. _____ ☐ - I do not wish to participate in any experimental drug studies or drug trials.

OR

2. _____ ☐ - I authorize my agent to consent to my participation in experimental drug studies or drug trials if my agent, after consultation with my treating physician and any other individuals my agent may think appropriate, determines 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.

G. Notification of Others, Visitors, and Consent to Release Information

1. _____ ☐ - If I am admitted to a psychiatric facility, I authorize staff to notify the following individuals (be sure to list your health care agent, if you have one).

   Name: _____

   Contact info: _____

   Name: _____

   Contact info: _____

   Name: _____

   Contact info: _____

2. _____ ☐ - I agree that the following people may visit me while I am receiving care in a psychiatric facility (be sure to list your health care agent, if you have one).

   _____

   _____

   _____

3. _____ ☐ - I do not agree that the following people may visit me while I am receiving care in a psychiatric facility.

   _____

   _____

4. _____ ☐ - I My health care agent is my "personal representative" as defined under the Health Insurance Portability and Accountability Act (HIPAA), and has the legal authority to view my mental health records, physical health records and to receive all protected health information about me.

   I authorize my health care agent to release the following records or other protected health information to the following individuals:

   a. ____ ☐ - I any and all mental health records

   OR

   b. ____ ☐ - I only the following Information (check those that apply):

   ☐ - Diagnosis ☐ - Medications ☐ - Treatment Plan
   ☐ - Discharge Plan ☐ - Progress/Status
   ☐ - Other: _____

   c. ____ ☐ - any and all physical health records

5. Individuals who may receive records and/or information from my health care agent (you may note any limitations you want applicable to a specific individual that you name. For example--- "Joe Smith" may get all mental health and physical records, while "Jane Jones" may only get my diagnosis and discharge plan information.):

   _____

   _____

H. Approaches that help me when I'm having a hard time

If I am having a hard time, the following approaches have been helpful in the past. I would like staff to try to use these approaches with me: *(Check all that apply)*

☐ - Voluntary time out in my room
☐ - Voluntary time out in quiet room
☐ - Calling my therapist
☐ - Deep breathing exercises
☐ - Having my hand held
☐ - Pounding some clay
☐ - Taking a shower
☐ - Listening to music
☐ - Talking with a peer
☐ - Pacing the halls
☐ - Writing in a journal
☐ - Talking with staff
☐ - Punching a pillow
☐ - Going for a walk
☐ - Reading
☐ - Watching TV
☐ - Lying down
☐ - Exercising
☐ - Calling a friend
☐ - Sitting by staff

Other: _____

_____

I. Special considerations regarding touch/body space: *(Check all that apply)*

____ ☐ **-** I do not wish to be touched
____ ☐ - I wish to be asked permission before being touched
____ ☐ **-** I wish to be told reasons why I am being touched
____ ☐ **-** I wish special attention to be given to allowing me extra personal body
____ ☐ **-** I do not need special attention given to my body space.

J. Additional preferences regarding my mental health care and treatment:

_____

_____

_____

K. Other existing co-occurring (physical and/or substance use) health related conditions, for example: diabetes, allergies, alcohol dependence, etc.)

_____

_____

SECTION II. APPOINTMENT OF AGENT FOR MENTAL HEALTH CARE

A. Designation of Mental Health Care Agent

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 upon my admission to a psychiatric hospital or crisis bed.

Name: _____

Address: _____

_____
City *State* *Zip Code*

Phone Number: _____
Home Cell Work

B. Designation of Alternate Mental Health Care Agent

If the person named above is unavailable or unable to serve as my agent, I hereby appoint the following person to serve as my alternate agent. This person is to be notified immediately of my admission to a psychiatric hospital or crisis bed:

Name: _____

Address: _____

_____

City *State* *Zip Code*

Phone Number: _____

Home Cell Work

C. Agent Instructions

_____ ☐ - I authorize my agent to make decisions on my behalf only in accordance with my expressed wishes as stated in this document.

_____ ☐ **-** I authorize my agent to make decisions on my behalf in accordance with my expressed wishes, as stated in this document or as otherwise made known to my agent. If I have not expressed a choice about a certain proposed mental health treatment, I authorize my agent to make the decision he or she reasonably determines that I would make if I were competent to do so. If my agent is unable to reasonably determine what my decision would be, I authorize my agent to make a decision that is in my best interest after reviewing the benefits, burdens and risks that might result from a given treatment or course of treatment, or from the withholding or withdrawal of a treatment or course of treatment.

SECTION III. CANCELLATION OF ADVANCE DIRECTIVE

____ ☐ **-** I intend that I may cancel any part or all of this Advance Directive, including my appointment of a health care agent, at any time, including during those periods when two physicians have documented in my medical record that I am not competent to make medical decisions. I understand that, under Maryland law at the time this Advance Directive is signed and dated, I have the legal right to cancel my Advance Directive at any time.

____ ☐ **-** I intend that I may cancel any part or all of this Advance Directive, including my appointment of a health care agent, at any time, except for those periods when two physicians have documented in my medical record that I am not competent to make medical decisions. I understand that, under Maryland law at the time this Advance Directive is signed and dated, I have the legal right to revoke my Advance Directive at any time. However, I choose to freely

waive this right and intend that the provisions regarding my mental health treatment contained in this Advance Directive and/or as authorized by my health care agent are implemented despite any verbal objection made by me while I am not competent.

SECTION IV. SIGNATURE

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

_____ _____

Signature Date

The above named person signed or acknowledged signing this Advance Directive in my company, and based upon my personal judgment appears to be competent.

_____ _____

Witness Name Witness Signature

_____ _____

Witness Name Witness Signature