

Montana Advanced Directive For Mental Health Care

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I, _____, with capacity, do knowingly
and voluntarily execute this advance directive for mental health care on this _____ day
of _____, 20____.

To the extent that this document includes private health care information I hereby waive my
privacy thereto for the purpose herein only, and specifically release my medical information
to those providers listed in this document.

Section 1. Period of validity of this directive.

(Choose one option by initialing).

_____ This directive is valid indefinitely, or until I execute a later advanced directive for mental health care.

_____ This directive is valid for _____ days after the date of signature.

_____ This directive is valid until this _____ day of _____, 20_____.

**Section 2. Appointment of agent for mental health care decision-making.
(Choose at least one option below by initialing).**

_____ I choose not to designate an agent to express my mental health care decisions for me when I lack the capacity to express those decisions myself. This advance directive provides sufficient consent, under Montana law, for services and treatments described in this directive without need of agent's further consent.

_____ I designate an agent to express my health care decisions during a period where I lack capacity.

Name: _____

Mailing address: _____

Telephone number: _____

Email address: _____

Other information: _____

_____ I designate an alternative agent in case my primary agent becomes unavailable.

The alternate agent is:

Name: _____

Mailing address: _____

Telephone number: _____

Email address: _____

Other information: _____

Section 3. When this directive goes into effect.

This mental health care directive goes into effect only after the health care provider who is in charge of my care at the time determines that I have lost the capacity to consent to mental health treatment.

This directive, and the power exercised by any agent I have hereby appointed, is in effect only as long as I remain incapacitated.

This Advance Directive may be over-ridden by a District Judge if I am involuntary committed by a civil or criminal court, but it may still provide valuable guidance to my providers and to the court during any period of commitment and it should be considered whenever decisions are being made about my medical care.

By creating this directive, I exercise a right to make decisions about my medical care that is protected under Montana and the United States Constitution.

Section 4. My instructions regarding revocability

(Choose ONLY ONE option by initialing. The third option has been given special emphasis so that it gets careful consideration).

_____ After I have been found to lack capacity to make medical decisions. I may revoke all or part of this directive at any time, including the nomination of my agents of in writing, with my signature, or my personally informing the health care provider who is in charge of my care at the time of recovery.

_____ After I have been found to lack capacity, my directive is irrevocable for the following period of time:

_____ (indicate a period of time)

_____ I give up my right to revoke this directive for as long as I lack capacity to make medical decisions.

_____ I understand that this means that I am giving up the power to say “no”, as long as I am incapacitated, to any mental health treatment that I consent to in this directive.

OR:

_____ Nevertheless, it is my informed and voluntary decision that this directive during any time that I am determined to lack capacity, even over my own protest.

Section 5. The determination on incapacity.

I understand that the health care provider who is primarily responsible for my care at the time may make the determination that I have lost the capacity to make health care decisions. (*You may impose special conditions by initialing one or more options, below*).

_____ For the purpose of triggering this advance directive, a second health care provider must agree, after examining me, that I no longer have the capacity to make decisions about my need for treatment.

_____ I further direct that the provider must be:

- A medical doctor
- A psychiatrist (A psychiatrist is a medical doctor with specialized training)

_____ In making the determination about my capacity, my health care provider(s) must consider the following information about me.

Section 6: The powers and duties of my agent, if I have one.

My agent has the power to express my consent to mental health treatment when I have been found to lack capacity.

My agent must follow my specific instructions in this directive. If my agent is asked to make decisions that are not addressed in the directive, then the decision must be based on how I would make the decision if I had the capacity. My agent must consider my own values and experience in making decisions, and may not substitute his or her own values and judgement about what would be best for me.

My agent can resign by giving me written notice. If my agent resigns while this Advanced Directive is in effect, my agent must give the written notice to my treating provider.

Section 7. Consent to treatment.

Choose the treatment you consent to by initializing next to the statement. You may give additional instructions on a separate piece of paper attached to this form.

By signing your initials, you are making a medical decision and giving a medical provider permission to provide that care.

If you write instructions, be *very clear* whether the instructions express a preference or a restriction. For instance, “I would like Dr. Brown to be my therapist” expresses a preference.

a. _____ I consent to treatment by any other provider who is assigned to care for me, though I prefer to receive care from the following person(s):

d. Medication

(i)_____ I consent to medications as prescribed by my treating provider. My **preferences**, which are intended as guidance to my treating provider, are:

(ii)_____ I consent **ONLY** to the following medication or medications, if prescribed:
(You can include explanations for your choices).

e. _____ I consent to electro-convulsive therapy (**ECT**). My consent is limited as follows:

_____ I consent to maximum number of _____ **ECT** treatments.

_____ I consent to **ECT** treatment **only** by the following providers(s):

_____ I **do not** consent to electro-convulsive therapy (**ECT**) under any circumstances.

f. _____ I consent to hospitalization and treatment in a hospital or a secure treatment facility, with **my consent** is limited to the following facilities:

(i) _____ My consent includes voluntary admission to the Montana State Hospital.

(ii) _____ My consent to hospitalization or treatment in a secure facility is limited to no more than _____ days or _____ weeks.

Section 10. Attachments. I have attached additional information to this Advanced Directive for mental health care. The following documents are part of this directive:

Section 11. My duty to provide a copy of my directive.

My provider must ask if I have an Advanced Directive and must include a copy of the directive in my file, if it is provided. It is my responsibility to share my directive with providers, agents and others so that it is available in a crisis.

Section 12. Liability

Photocopies of this document can be relied upon as though they were originals.

It is my intent that no one involved in my care shall be liable for honoring this directive or following the directions of my agent.

I understand that my health care provider must comply with the terms of this Advance Directive as much as possible after I have been determined to lack capacity to make health care decisions. However, I understand that this directive cannot obligate anyone to pay for services rendered to me, nor obligate anyone to provide me with services that are outside their normal scope of service.

I also understand that my provider does not have to provide me with any treatment that is not reasonably available, that would violate the accepted standard of care, or that would conflict with a law or a court order. My provider is not required to follow my directive in an emergency situation if it would endanger my life or health.

