

# Instructions and Forms

## MENTAL HEALTH ADVANCED DIRECTIVES

FOR PENNSYLVANIANS

### MENTAL HEALTH ADVANCE DIRECTIVE

I, \_\_\_\_\_,  
have executed an advance directive specifying my  
decisions about my mental health care. **My Mental Health  
Care Agent** is \_\_\_\_\_.  
If I am hospitalized, my **Agent** should be immediately  
contacted at \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_.

If the hospital has questions about its legal responsibilities to honor my decisions,  
it should contact  
**Pennsylvania Protection and Advocacy**  
**at:**  
**1-800-692-7443**

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## I. INTRODUCTION

On November 3, 2004, Governor Rendell signed House Bill 2036 into law making it Act 194 of 2004. By allowing you to create a Mental Health Advance Directive – which can include a Declaration and/or a Mental Health Power of Attorney – this new law promotes planning ahead for the mental health services and supports that you might want to receive during a crisis if you are unable to make decisions.

Act 194 became effective on January 29, 2005. The passage of this legislation is largely the result of collaboration between advocacy organizations, county governments, professional associations and the state government. A Mental Health Care Advance Directive is a tool that focuses on wellness and recovery planning. Pennsylvania is pleased to join the national trend of promoting the use of this tool as a mental health policy.

It is important to understand how to make this new law work for you – including how to create an Advance Directive and/or appoint an agent for your mental health Power of Attorney.

This booklet has been developed to assist you. It includes forms and instructions that you can use to create your advance directive and answers to frequently asked questions. If you have additional questions or need assistance with completing a form, contact any one of the following organizations:

- Pennsylvania Mental Health Consumers' Association  
1-800-88PMHCA  
pmhca@pmhca.org
- Pennsylvania Protection & Advocacy / Disabilities Law Project  
1-800-692-7443  
717-236-8110  
1-877-375-7139 (TDD/TTY)
- Mental Health Association in Pennsylvania  
1-866-578-3659  
717-346-0549 info@mhapa.org

## II. FREQUENTLY ASKED QUESTIONS

### What is a Mental Health Advance Directive?

A Mental Health Advance Directive is a document that allows you to make your choices known regarding mental health treatment in the event that your mental illness makes you unable to make decisions. In effect, you are making decisions about treatment before the time that you will need it. This allows you to make more informed decisions and to make your wishes clearly known. A new law was passed in Pennsylvania, effective January 28, 2005, that makes it possible for you to use a Mental Health Advance Directive.

Many decisions may need to be made for you if you have a mental health crisis or are involuntarily committed and become unable to make treatment decisions. For example, the choice of hospital, types of treatment, and who should be notified are decisions that may be made for you. Unfortunately, at the time of crisis, you may not be able to make your wishes known, and therefore you may end up with others making decisions that you would not make. One way to be sure that your doctor, relatives, and friends understand your feelings is to prepare a Mental Health Advance Directive before you become unable to make decisions. Pennsylvania law allows you to make a Mental Health Advance Directive that is a declaration, a power of attorney, or a combination of both.

### What is a Declaration?

A Declaration contains instructions to doctors, hospitals, and other mental health care providers about your treatment in the event that you become unable to communicate your wishes. A Declaration usually deals with specific situations and does not allow much flexibility for changes that come up after the document is written, such as a new type of medical crisis, new kinds of medication, or different treatment choices.

### What is a Mental Health Power of Attorney?

A Mental Health Power of Attorney allows you to designate someone else, called an agent, to make treatment decisions for you in the event of a mental health crisis. A Mental Health Power of Attorney provides flexibility to deal with a situation as it occurs rather than attempting to anticipate every possible situation in advance.

When using a Mental Health Power of Attorney it is very important to choose someone you trust as your agent and to spend time with that person explaining your feelings about treatment choices. Your doctor or his/her employee, or an owner, operator, or employee of a residential facility where you are living cannot serve as an agent.

### What is a Combined Mental Health Declaration and Power of Attorney?

Pennsylvania's law also allows you to make a combined Mental Health Declaration and Power of Attorney. This lets you make decisions about some things, but also lets you give an agent power to make other decisions for you. You choose the decisions that you want your agent to make for you, as many or as few as you like. This makes your Mental Health Advance Directive more flexible in dealing with future situations, such as new treatment options, that you would have no way of knowing about now.

Your agent should be someone you trust, and you should be sure to discuss with your agent your feelings about different treatment choices so that your agent can make decisions that will be most like the ones you would have made for yourself.

### What makes a Mental Health Care Advance Directive valid?

There is no specific form that must be used, but your Mental Health Advance Directive must meet the following requirements:

1. You must be at least 18 years of age.
2. You must not have been declared incapacitated by a court and had a guardian appointed or currently be under an involuntary commitment.
3. The Mental Health Advance Directive must be signed, witnessed and dated. Witnesses must be at least 18 years old. If you cannot physically sign the document, another person may sign for you, but the person signing may not also be a witness. Your doctor or his/her employee, or an owner, operator, or employee of a residential facility where you are living cannot serve as an agent.

4. The Mental Health Advance Directive must contain your choices about beginning, continuing, or refusing mental health treatment. The Mental Health Advance Directive also can include choices about other things, such as who you want to be your agent or guardian, who you want to care for your children or pets, who you want notified about your condition, and/or your dietary or religious choices.
5. If your Mental Health Advance Directive is a Power of Attorney, then you must name the person you want to be your agent and say that you are authorizing them to make whatever decisions you want them to make.

The Mental Health Advance Directive is valid for two years from the date you sign it unless one of the following happens first:

- a. You revoke the entire Mental Health Advance Directive, or
- b. You make a new Mental Health Advance Directive.

If you do not have capacity to make treatment decisions at the time the Mental Health Advance Directive will end, the Advance Directive will stay in place until you are able to make treatment decisions.

### What is Capacity?

Capacity is the basic ability to understand your diagnosis and to understand the risks, benefits, and alternative treatments of your mental health care. It also includes the ability to understand what may happen if you do not receive treatment.

### Do I need to include proof of my capacity with the document?

No, unless you have a guardian or are currently under an involuntary commitment, you are presumed to have capacity when you make a Mental Health Advance Directive. However, at a later time it is possible for someone to challenge whether you had capacity. If you want to be very sure that no one can challenge your Mental Health Advance Directive later, you can include a letter from your treating doctor from the same time period that you made your directive stating that you had capacity at that time.

### When would my Mental Health Advance Directive take effect?

You can write in your Mental Health Advance

Directive when you want the directive to take effect, for example, when involuntary commitment occurs, or when a psychiatrist and another mental health treatment professional states you no longer have capacity to make mental health treatment decisions.

### Who will determine that I don't have capacity to make mental health decisions?

For the purpose of your Mental Health Advance Directive, incapacity will be determined after you are examined by a psychiatrist and one of the following: another psychiatrist, psychologist, family physician, attending physician, or mental health treatment professional. Whenever possible, one of the decision makers will be one of your current treating professionals.

### What if a court appoints a guardian after I have appointed an agent to make my mental health care decisions?

In your Advance Directive you can name someone you want the court to choose as your guardian. The court will appoint the person you choose, unless there is a good reason not to. In many cases your agent and the person you would want to be your guardian would be the same person. However, you may want one person to make your mental health care decisions, and someone else to make other decisions for you. If the court-appointed guardian and your agent are different people, the court will allow your agent to make mental health care decisions, unless you say otherwise in your Mental Health Advance Directive. If the court decides to grant the powers that you gave to an agent to the guardian, the guardian would still have to make decisions as written in your Advance Directive.

### May I make changes to my Mental Health Advance Directive?

You may change your Mental Health Advance Directive in writing at any time, as long as you have capacity. If you make significant changes, you should make a new document so that there are no conflicts or misunderstandings. Remember that your changes or a new directive must be witnessed by two individuals, at least 18 years of age, and you should give new copies to your provider, agent, and other support people.

### May I revoke my Mental Health Advance Directive?

You may revoke, or in other words, cancel, a part or the whole Mental Health Advance Directive at any time, as long as you have capacity. This may be done either orally or in writing. It is effective as soon as you tell your provider. Your Advance Directive will automatically end after two years from the date you signed it unless you do not have capacity to make mental health care decisions at that time. If you do not have capacity at the time it would end, the Mental Health Advance Directive will stay in force until you regain capacity.

### What types of instructions should I include?

A Mental Health Advance Directive is a way to communicate lots of information to your provider. You may wish to include your choices about different treatment options, such as medications, electro-shock therapy, and crisis management. In addition, you may say who you want to be told in the event of a crisis, or write down your dietary choices, past treatment history, who you want to take care of your children or pets, and other information that you want to be taken care of while you seek treatment.

### Who should I give my Mental Health Advance Directive to?

The only way that your providers will know what your choices are is if you give them your Mental Health Advance Directive. You should also give copies to your treating physician, agent, and family members or other people that would be notified in the event of a crisis. Keep the original in a safe place, and be sure that someone who would be told of any crisis can get the original so it can be given to the attending physician. You may wish to carry a card in your wallet that states that you have a Mental Health Advance Directive, and who should be called in the event that you lack capacity to make mental health care decisions. Include that person's phone numbers, and also name another person in case the first person is not available. Remember that if you make changes or create a new Mental Health Advance Directive you must be sure that everyone has copies of the most recent version.

### Do health care providers have to follow my instructions?

Yes, unless a provider cannot in good conscience comply with your instructions because they are against accepted clinical or medical practice, or because the policies of the provider, such as what is covered by insurance, do not allow compliance, or because the treatment is physically unavailable. If the provider cannot comply for any of these reasons, the provider must tell you or your agent as soon as possible. It is very helpful to discuss your decisions with your provider when you make your Mental Health Advance Directive, so that you know whether they will be able to follow your instructions.

Remember that even if you consent in advance to a particular medication or treatment, your doctor will not prescribe that treatment or drug unless it is appropriate at the time you are ill. Your consent is only good if your choices are okay at that time, within the standards of medical care. Your doctor will also have to consider if a particular treatment option is covered by your insurance. If, for example, the HMO that you have does not cover a certain drug on its formulary, your doctor may prescribe a drug that is similar, but is on the HMO formulary, as long as you have not withheld consent to that particular drug.

### How does a Mental Health Advance Directive affect involuntary commitment?

The voluntary and involuntary commitment provisions of the Mental Health Procedures Act are not affected by having a Mental Health Care Advance Directive. What may be affected is how you can be treated after you are committed.

COMBINED

# Mental Health Declaration and Power of Attorney



## III. COMBINED

Pennsylvania's law allows you to make a combined Mental Health Declaration and Power of Attorney. This lets you make decisions about some things, but also lets you give an agent power to make other decisions for you. You choose the decisions that you want your agent to make for you, as many or as few as you like. This makes your Mental Health Advance Directive more flexible in dealing with future situations, such as new treatment options, that you would have no way of knowing about now.

You are presumed to be capable of making an Advance Directive unless you have been adjudicated, incapacitated, involuntarily committed, or found to be incapable of making mental health decisions after examination by both a psychiatrist and another doctor or mental health professional.

### Basic Instructions

The following corresponds to the form on page 27.

**Read each section very carefully.** Begin by printing your name in the blank in the introductory paragraph at the top of the page.

### Part I: Introduction

#### A. When this Declaration becomes effective

Decide when you want the Declaration to become effective. You can specify a condition, such as if you are involuntarily committed for either outpatient or inpatient care, or some other behavior or event that you know happens when you no longer have capacity to make mental health decisions, or you can specify that you want an evaluation for incapacity.

If you do not choose a condition, your incapacity will be determined after examination by a psychiatrist and one of the following: another psychiatrist, psychologist, family physician, attending physician, or other mental health treatment professional. If you have doctors that you would prefer to make the evaluation, you should specify them in your Declaration. Although that doctor may not be available, an effort will at least be made to contact them.

Until your condition is met, or you are found to be unable to make mental health decisions, you will make decisions for yourself.

#### B. Revocations and Amendments

Revocation means that you are canceling your Directive. If you revoke your Directive, your doctor will no longer have to follow the instructions that you gave in the document. You may change or revoke your Directive at any time, as long as you have capacity to make mental health decisions when you make the change or revocation. You may revoke a specific instruction without revoking the entire document.

If you are currently under an involuntary commitment and you want to change or revoke your Declaration, you will need to request an evaluation to determine if you are capable of making mental health decisions. The evaluation will be done by a psychiatrist and another psychiatrist, psychologist, family physician, attending physician or other mental health professional. If you are found to have the capacity to make mental health decisions, you will be able to revoke or change your Declaration, even though you are in the hospital.

You may revoke your Mental Health Advance Directive orally or in writing. Your Advance Directive will terminate as soon as you communicate your revocation to your treating doctor. It is best to make any changes or revocation in writing, because then there is a clear record of your wishes.

If you make a new Mental Health Advance Directive, you should be sure to notify your doctor and support people that you have revoked the old one. Your Directive will automatically expire two years from the date you made it, unless you are unable to make mental health decisions for yourself at the time it would expire. In that case, it will remain in force until you are able to make decisions for yourself.

To amend your Directive means that you make changes to it. You may make changes at any time, as long as you have capacity to make mental health care decisions. Any changes must be made in writing and be signed and witnessed by two individuals in the same way as the original document. Any changes will be effective as soon as the changes are communicated to your attending physician or other mental health care provider, either by you, or a witness to your amendments.

## C. Termination

Your Advance Directive will automatically expire two years from the date of execution, unless you have been found incapable of making mental health care decisions at the time the directive would expire. In that case, the Declaration will continue to be in force until you regain capacity.

## Part II: Mental Health Declaration

### A. Treatment preferences

Your Advance Directive will be less likely to be challenged if you include information about what you do want, as well as what you don't want.

Remember that consenting in advance to a particular medication or treatment does not mean your doctor will prescribe that treatment or drug unless it is appropriate treatment at the time you are ill. Consent only means that you consent if it is a suitable choice at that time within the standards of medical care. Your doctor will also have to consider if a particular treatment option is covered by your insurance. If, for example, the HMO that you have does not cover a certain drug on its formulary, your doctor may prescribe a drug that is similar, but is on the HMO formulary as long as you have not withheld consent to that particular drug.

Make sure to mark your preference in each section with your initials. Although you do not have to explain your choices, it is helpful if you include statements explaining why you want or don't want any specific treatments. If any of your choices are challenged, you will have a better chance of having your choice honored if a court understands what your reasons are for making your choice. If you do not have a preference in a given section, you may leave it blank.

#### 1. Choice of Treatment Facility

If you have a preference for, or bad feelings toward, any particular hospital, list them here. Unfortunately, there are times when a particular place is already full and would be unable to accommodate you, or the treating doctor does not have privileges at the hospital you would prefer. Therefore, although your doctor will try to respect your choice, it may not always be possible.

## 2. Medications

If you give instructions about medications, be sure to give reasons for your decisions. If, for instance, you experienced unacceptable side effects from a particular generic or dose, you would want to be specific so that your treating doctor understands your concern. That way your doctor will be less likely to prescribe something else that is likely to cause similar problems. Likewise, if you know that a specific medication has worked for you in the past, you should be sure to include that information. If a time-released version works, but the regular brand does not, you should be sure you include that information. The more your doctor knows about you, the more likely you are to get the right treatment, faster.

Be careful what you specify. Medications come in brand and generic names, and also belong to broader classes of drugs, such as "atypical antipsychotics" or "SSRIs." If you rule out an entire class of drugs, you should be aware that a new, helpful drug may come on the market that could be ruled out, even though you don't actually know anything about it.

You may choose to let your agent make decisions related to the use of medications. If you choose this option, be sure to discuss your feelings and prior experiences with your agent.

You may choose not to consent to the use of any medications. Just be aware that you will also be ruling out new medications that could be helpful in your treatment. Your Advance Directive may also be challenged if your doctor believes that you will be irreparably harmed by this choice.

## 3. Preferences related to electroconvulsive therapy (ECT)

In some cases, a doctor may find that ECT would be an effective form of treatment. If you have found ECT helpful in the past, or you trust your doctor to make that decision on your behalf, you may decide to consent to this treatment in advance.

You may choose to let your agent make decisions related to ECT. If you choose this option, be sure to discuss your feelings and prior experiences with ECT with your agent.

If you do not wish to undergo ECT under any circumstances, you should initial the line next to "I do not consent to the administration of electro-convulsive therapy." **NOTE: Your agent is NOT allowed to consent to ECT unless you initial this authorization.**

#### 4. Preferences for experimental studies

Opportunities may exist for you to participate in experimental studies related to treatment of your illness. Sometimes these studies provide more data that helps doctors determine the cause or best practice for treating an illness. Sometimes the studies are based on the idea that a certain new treatment might help. If you participate in a study, you may have access to a new treatment sooner than you would otherwise. However, there may be some level of risk involved. If you want to participate in a study because your doctor believes that the potential benefits to you outweigh the potential risks, you should initial the first choice.

You may choose to let your agent make decisions related to your participation for experimental studies. It is important that your agent understand the kind of studies that you would object to. For example, you may wish to participate only if the study does not include medication or any invasive procedures.

If you do not want to participate in experimental studies of any kind, under any circumstances, you should initial the choice that states that you do not consent.

**NOTE: Your agent is NOT allowed to consent to experimental studies unless you initial this authorization.**

#### 5. Preferences regarding drug trials

Similarly, you may have the opportunity to participate in a trial related to new medications. If you participate, you may have access to a new drug sooner than you would otherwise. However, there may be risks or side effects.

If you want to participate in a drug trial if your doctor believes that the potential benefits to you outweigh the potential risks, you should initial the first choice.

You may choose to let your agent make decisions related to your participation in drug trials. It is important that your agent understand any particular risks that you would not be willing to take so that he/she can make the decision you would make given the same information.

If you do not want to participate in a drug trial of any kind, under any circumstances, you should initial the choice that states that you do not consent. **NOTE: Your agent is NOT allowed to consent to research including drug trials unless you initial this authorization.**

#### 6. Additional instructions or information

One of the significant benefits of filling out an Advance Directive is that you are communicating important information to your mental health care provider, agent, and others who support you. This part of your form allows you to provide information that may or may not be directly related to your mental health treatment. If there is other information that you would like your mental health care provider and agent to know you should include it here. You can attach an additional page to the form if there is not enough room to write everything you need to. Just be sure that you print or type your statements, and try to make them as clear as possible, to minimize confusion about what you want to happen. Again, if you do not have a preference about something listed or you are comfortable letting your agent make that particular decision, just leave that particular section blank.

### Part III: Mental Health Power of Attorney

Begin by printing your name in the blank in the first paragraph stating that you are authorizing a designated health care agent to make certain decisions on your behalf.

## A. Designation of Agent

You may name any adult who has capacity as your agent, with the following exceptions: your mental health care provider or an employee of your mental health care provider or an agent, operator, or employee of a residential facility in which you are receiving care may not serve as your agent unless they are related to you by marriage, blood or adoption.

Write in the name of the person you choose, and fill in their address and phone number. You want the person to be contacted anytime, so add as much information as possible, including work and home phone numbers. The person that you choose as your agent should also sign the document to indicate that he/she accepts serving as your agent.

Since your agent will be making decisions on your behalf, it is very important to choose someone you trust and to discuss your ideas and feelings in detail so that the person really understands what mental health decisions you would have made for yourself.

## B. Designation of an Alternative Agent

You may wish to designate an alternative person in case the first person you chose is unavailable. This is a good idea if you have another person that you trust, since people may be unavailable for a variety of reasons such as illness or travel. If you do not have any one that you wish to name as an alternative, leave this section blank.

The person that you choose as your alternative agent should also sign the document to indicate that he/she accepts serving as your agent. Your alternative agent must fill in his/her address and phone number so that they can be reached by your provider.

## C. Authority Granted to Agent

You may grant full power and authority to your agent to make all of your mental health care decisions, or you can set limits on the kinds of decisions your agent may make on your behalf. If you wish to limit the decisions your agent can make you should read each subsection carefully and initial your choice. Your agent cannot consent to electroconvulsive therapy, experimental procedures or research unless you expressly grant those powers by initialing consent in those sections. If there is some other mental health care decision that you do not want your agent to be able to make, you may write it in. Be sure to write clearly, so there is no room for confusion.

The Pennsylvania law does not allow your agent to consent to psychosurgery or the termination of parental rights on your behalf, even if you are willing for your agent to have that power.

## Part IV: Nominating a Guardian

### A. Preference as to a court-appointed guardian

If you become incapacitated, it is possible that a court may appoint a guardian to act on your behalf. Under the guardianship laws, you may nominate a guardian of your person for consideration by the court. The court will appoint your guardian in accordance with your most recent nomination except for good cause or disqualification. If you wish to name someone in your Declaration, it is important that you talk to that person about whether they feel they can serve as your guardian, because a court will not force them to serve. It is also important that you give that person a copy of your Power of Attorney and explain your wishes regarding mental health treatment.

If the court appoints a guardian, that person will not be able to terminate, revoke or suspend your Declaration unless you want them to be able to. In this section, you should decide whether you want a court appointed guardian to have that power. Even if you do not specify a person that you would want as a guardian, you can still specify whether a person that is appointed by the court is allowed to terminate, revoke or suspend your Declaration.

If the court-appointed guardian and your agent turn out to be different people, the court will give preference to allowing your mental health care agent to continue making mental health care decisions as provided in your Directive, unless you specify otherwise in your Directive. If, after thorough examination, the court decides to grant the powers that you gave to an agent to the guardian, the guardian would still be bound by the same obligations that your agent would have been.

## Part V. Execution

**You must sign and date your Combined Mental Health Care Declaration and Power of Attorney in this section.** If you are unable to sign for yourself, someone else may sign on your behalf.

**Your document must be signed and dated by you in the presence of two witnesses.** Each witness must be at least 18 years old. The witnesses may not be your agent or a person signing on your behalf.

In order for your Declaration to be effective, you must be sure that the right people have access to it. Be sure to give copies of this Advance Directive to your agent, mental health care provider, and anyone else that may be notified in the event that you are found not to have capacity to make mental health care decisions. Remember that if you cancel or change your document you must let everyone know. It is a good idea to carry a card in your wallet to let people know that you have an Advance Directive.

**Please Note: The information in this document is not intended to constitute legal advice applicable to specific factual situations. For specific advice contact the Disabilities Law Project/Pennsylvania Protection & Advocacy (DLP/PP&A) intake line at 1-800-692-7443 (voice) or 1-877-375-7139 (TDD).**

MENTAL HEALTH  
**Declaration**

## IV. DECLARATION

A Declaration contains instructions to doctors, hospitals, and other mental health care providers about your treatment in the event that you become unable to make decisions or unable to communicate your wishes. A Declaration usually deals with specific situations and does not allow much flexibility for changes that come up after the document is written, such as a new type of medical crisis, new kinds of medication, or different treatment choices.

You are presumed to be capable of making an Advance Directive unless you have been adjudicated, incapacitated, involuntarily committed, or found to be incapable of making mental health decisions after examination by both a psychiatrist and another doctor or mental health professional.

### Basic Instructions

The following corresponds to the form on page 35.

Read each section very carefully. Begin by printing your name in the blank in the introductory paragraph at the top of the page.

#### A. When this Declaration becomes effective

Decide when you want the Declaration to become effective. You can specify a condition, such as if you are involuntarily committed for either outpatient or inpatient care, or some other behavior or event that you know happens when you no longer have capacity to make mental health decisions, or you can specify that you want an evaluation for incapacity.

If you do not choose a condition, your incapacity will be determined after examination by a psychiatrist and one of the following: another psychiatrist, psychologist, family physician, attending physician, or other mental health treatment professional. If you have doctors that you would prefer to make the evaluation, you should specify them in your Declaration. Although that doctor may not be available, an effort will at least be made to contact them.

Until your condition is met, or you are found to be unable to make mental health decisions, you will make decisions for yourself.

#### B. Treatment preferences

Your Advance Directive will be less likely to be challenged if you include information about what you do want, as well as what you don't want.

Remember that consenting in advance to a particular medication or treatment does not mean your doctor will prescribe that treatment or drug unless it is appropriate treatment at the time you are ill. Consent only means that you consent if it is a suitable choice at that time within the standards of medical care. Your doctor will also have to consider if a particular treatment option is covered by your insurance. If, for example, the HMO that you have does not cover a certain drug on its formulary, your doctor may prescribe a drug that is similar, but is on the HMO formulary as long as you have not withheld consent to that particular drug.

Make sure to mark your preference in each section with your initials. Although you do not have to explain your choices, it is helpful if you include statements explaining why you want or don't want any specific treatments. If any of your choices are challenged, you will have a better chance of having your choice honored if a court understands what your reasons are for making your choice. If you do not have a preference in a given section, you may leave it blank.

##### 1. Choice of Treatment Facility

If you have a preference for, or bad feelings toward, any particular hospital, list them here. Unfortunately, there are times when a particular place is already full and would be unable to accommodate you, or the treating doctor does not have privileges at the hospital you would prefer. Therefore, although your doctor will try to respect your choice, it may not always be possible.

##### 2. Medications

If you give instructions about medications, be sure to give reasons for your decisions. If, for instance, you experienced unacceptable side effects from a particular generic or dose, you would want to be specific so that your treating doctor

understands your concern. That way your doctor will be less likely to prescribe something else that is likely to cause similar problems. Likewise, if you know that a specific medication has worked for you in the past, you should be sure to include that information. If a time-released version works, but the regular brand does not, you should be sure you include that information. The more your doctor knows about you, the more likely you are to get the right treatment, faster.

Be careful what you specify. Medications come in brand and generic names, and also belong to broader classes of drugs, such as "atypical antipsychotics" or "SSRIs." If you rule out an entire class of drugs, you should be aware that a new, helpful drug may come on the market that could be ruled out, even though you don't actually know anything about it.

You may choose not to consent to the use of any medications. Just be aware that you will also be ruling out new medications that could be helpful in your treatment. Your Advance Directive may also be challenged if your doctor believes that you will be irreparably harmed by this choice.

### **3. Preferences related to electroconvulsive therapy (ECT)**

In some cases, a doctor may find that ECT would be an effective form of treatment. If you have found ECT helpful in the past, or you trust your doctor to make that decision on your behalf, you may decide to consent to this treatment in advance.

If you do not wish to undergo ECT under any circumstances, you should initial the line next to "I do not consent to the administration of electroconvulsive therapy."

### **4. Preferences for experimental studies**

Opportunities may exist for you to participate in experimental studies related to treatment of your illness. Sometimes these studies provide more data that help doctors determine the cause or best practice for treating an illness.

Sometimes the studies are based on the idea that a certain new treatment might help. If you participate in a study, you may have access to a new treatment sooner than you would otherwise. However, there may be some level of risk involved. If you want to participate in a study because your doctor believes that the potential benefits to you outweigh the potential risks, you should initial the first choice.

If you do not want to participate in experimental studies of any kind, under any circumstances, you should initial the choice that states that you do not consent.

### **5. Preferences regarding drug trials**

Similarly, you may have the opportunity to participate in a trial related to new medications. If you participate, you may have access to a new drug sooner than you would otherwise. However, there may be risks or side effects. If you want to participate in a drug trial because your doctor believes that the potential benefits to you outweigh the potential risks, you should initial the first choice.

If you do not want to participate in a drug trial of any kind, under any circumstances, you should initial the choice that states that you do not consent.

### **6. Additional instructions or information**

One of the significant benefits of filling out an Advance Directive is that you are communicating important information to your doctor and people who support you. This part of your form allows you to provide information that may or may not be directly related to your mental health treatment. If there is other information that you would like your doctor to know, you should include it here. You can attach an additional page to the form if there is not enough room to write everything you need to. Just be sure that you print or type your statements, and try to make them as clear as possible, to minimize confusion about what you want to happen. Again, if you do not have a preference about something listed, just leave that particular section blank.



### C. Revocations and Amendments

Revocation means that you are canceling your Declaration. If you revoke your Declaration, your doctor will no longer have to follow the instructions that you gave in the document. You may change or revoke your Declaration at any time, as long as you have capacity to make mental health decisions when you make the change or revocation. You may revoke a specific instruction without revoking the entire document.

If you are currently under an involuntary commitment, and you want to change or revoke your Declaration, you will need to request an evaluation to determine if you are capable of making mental health decisions. The evaluation will be done by both a psychiatrist and another psychiatrist, psychologist, family physician, attending physician or other mental health professional. If you are found to have the capacity to make mental health decisions, you will be able to revoke or change your Declaration, even though you are in the hospital.

You may revoke your Declaration orally or in writing. It becomes effective as soon as you communicate your revocation to your treating doctor. It is best to make any changes or revocation in writing, because then there is a clear record of your wishes.

If you make a new Declaration, you should be sure to notify your doctor and support people that you have revoked the old one. Your Declaration will automatically expire two years from the date you made it, unless you are unable to make mental health decisions for yourself at the time it would expire. In that case, it will remain in force until you are able to make decisions for yourself.

To amend your Declaration means that you make changes to it. You may make changes at any time, as long as you have capacity to make mental healthcare decisions. Any changes must be made in writing and be signed and witnessed by two individuals in the same way as the original document. Any changes will be effective as soon as the changes are communicated to your attending physician or other mental health care provider, either by you, or a witness to your amendments.

### D. Termination

Your Declaration will automatically expire two years from the date of execution, unless you have been found incapable of making mental health care decisions at the time the directive would expire. In that case, the Declaration will continue to be in force until you regain capacity.

### E. Preference as to a court-appointed guardian

If you become incapacitated, it is possible that a court may appoint a guardian to act on your behalf. Under the guardianship laws, you may nominate a guardian of your person for consideration by the court. The court will appoint your guardian in accordance with your most recent nomination except for good cause or disqualification. If you wish to name someone in your Declaration, it is important that you talk to that person about whether they feel they can serve as your guardian, because a court will not force them to serve. It is also important that you give that person a copy of your Declaration and explain your wishes regarding mental health treatment.

If the court appoints a guardian, that person will not be able to terminate, revoke or suspend your Declaration unless you want them to be able to. In this section, you should decide whether you want a court appointed guardian to have that power. Even if you do not specify a person that you would want as a guardian, you can still specify whether a person that is appointed by the court is allowed to terminate, revoke or suspend your Declaration.

### F. Execution

**You must sign and date your Declaration in this section.** If you are unable to sign for yourself, someone else may sign on your behalf. **Your document must be signed and dated by you in the presence of two witnesses.** Each witness must be at least 18 years old. If you are unable to sign the document yourself, you may have someone else sign on your behalf, but that person may not also be a witness.

In order for your Declaration to be effective, you must be sure that the right people have access to it. Be sure to give copies of this Advance Directive to your mental health care provider, and anyone else that may be notified in the event that you are found not to have capacity to make mental health care decisions. Remember that if you cancel or change your document you must let everyone know. It is a good idea to carry a card in your wallet to let people know that you have an Advance Directive.

**Please Note: The information in this document is not intended to constitute legal advice applicable to specific factual situations. For specific advice contact the Disabilities Law Project/Pennsylvania Protection & Advocacy (DLP/PP&A) intake line at 1-800-692-7443 (voice) or 1-877-375-7139 (TDD).**

MENTAL HEALTH

# Power of Attorney

## V. POWER OF ATTORNEY

A Power of Attorney allows you to designate someone else, called an agent, to make treatment decisions for you in the event of a mental health crisis. A Power of Attorney provides flexibility to deal with a situation as it occurs rather than attempting to anticipate every possible situation in advance. When using a Power of Attorney it is very important to choose someone you trust as your agent and to spend time with that person explaining your feelings about treatment choices. Your doctor or his/her employee, or an owner, operator, or employee of a residential facility where you are living cannot serve as an agent.

You are presumed to be capable of making an Advance Directive unless you have been adjudicated, incapacitated, involuntarily committed, or found to be incapable of making mental health decisions after examination by both a psychiatrist and another doctor or mental health professional.

### Basic Instructions

The following corresponds to the form on page 41.

**Read each section very carefully.** Begin by printing your name in the blank in the introductory paragraph at the top of the page.

#### A. Designation of Agent

You may name any adult who has capacity as your agent, with the following exceptions: your mental health care provider or an employee of your mental health care provider or an agent, operator, or employee of a residential facility in which you are receiving care may not serve as your agent unless they are related to you by marriage, blood or adoption.

Write in the name of the person you choose, and fill in their address and phone number. You want the person to be contacted anytime, so add as much information as possible, including work and home phone numbers. The person that you choose as your agent should also sign the document to indicate that he/she accepts serving as your agent.

Since your agent will be making decisions on your behalf, it is very important to choose someone you trust and to discuss your ideas and feelings in detail so that the person really understands what mental health decisions you would have made for yourself.

#### B. Designation of an Alternative Agent

You may wish to designate an alternative person in case the first person you chose is unavailable. This is a good idea if you have another person that you trust, since people may be unavailable for a variety of reasons such as illness or travel. If you do not have any one that you wish to name as an alternative, leave this section blank.

The person that you choose as your alternative agent should also sign the document to indicate that he/she accepts serving as your agent. Your alternative agent should fill in his/her address and phone number so that they can be reached by your provider.

#### C. When the Power of Attorney becomes effective

Decide when you want the Power of Attorney to become effective. You can specify a condition, such as if you are involuntarily committed for either outpatient or inpatient care, or some other behavior or event that you know happens when you no longer have capacity to make mental health decisions, or you can specify that you want an evaluation for incapacity.

If you do not choose a condition, your incapacity will be determined after examination by a psychiatrist and one of the following: another psychiatrist, psychologist, family physician, attending physician, or other mental health treatment professional. If you have doctors that you would prefer to make the evaluation, you should specify them in your Power of Attorney. Although that doctor may not be available, an effort will at least be made to contact them.

Until your condition is met, or you are found to be unable to make mental health decisions, you will make decisions for yourself.

## D. Authority granted to your Mental Health Care Agent

You may grant full power and authority to your agent to make all of your mental health care decisions, or you can set limits on the kinds of decisions your agent may make on your behalf. If you wish to limit the decisions your agent can make you should read each subsection carefully. If there is some other mental health care decision that you do not want your agent to be able to make, you may write it in. Pennsylvania law does not allow your agent to consent to psychosurgery or the termination of parental rights on your behalf, even if you are willing for your agent to have that power.

### 1. Treatment preferences

Remember that consenting in advance to a particular medication or treatment does not mean your doctor will prescribe that treatment or drug unless it is appropriate treatment at the time you are ill. Consent only means that you consent if it is a suitable choice at that time within the standards of medical care. Your doctor will also have to consider if a particular treatment option is covered by your insurance. If, for example, the HMO that you have does not cover a certain drug on its formulary, your doctor may pre-scribe a drug that is similar, but is on the HMO formulary as long as you have not withheld consent to that particular drug.

Although you do not have to explain your choices, it is helpful if you include statements explaining why you want or don't want any specific treatments. If you do not have a preference in a given section, you may leave it blank.

#### a. Choice of Treatment Facility

If you have a preference for, or bad feelings toward, any particular hospital, list them here. Unfortunately, there are times when a particular place is already full and would be unable to accommodate you, or the treating doctor does not have privileges at the hospital you would prefer. Therefore, although your doctor will try to respect your choice, it may not always be possible.

#### b. Preferences regarding medications

If you give instructions about medications,

be sure to give reasons for your decisions. If, for instance, you experienced unacceptable side effects from a particular generic or dose, you would want to be specific so that your treating doctor understands your concern. That way your doctor will be less likely to prescribe something else that is likely to cause similar problems. Likewise, if you know that a specific medication has worked for you in the past, you should be sure to include that information. If a time-released version works, but the regular brand does not, you should be sure you include that information. The more your doctor knows about you, the more likely you are to get the right treatment, faster.

Be careful what you specify. Medications come in brand and generic names, and also belong to broader classes of drugs, such as "atypical antipsychotics" or "SSRIs." If you rule out an entire class of drugs, you should be aware that a new, helpful drug may come on the market that could be ruled out, even though you don't actually know anything about it.

Giving your agent authority to make medication decisions allows more flexibility to deal with future situations. For instance, a new drug may come on the market that is not currently available. By allowing your agent to make the decision at the time of your incapacity means that your agent will have the most up-to-date information on which to base decisions.

### c. Preferences regarding electroconvulsive therapy (ECT)

In some cases, a doctor may find that ECT would be an effective form of treatment. If you have found ECT helpful in the past, and/or you trust your agent to make that decision if your doctor thinks it may help, you should initial the line next to "my agent is authorized to consent to the administration of electroconvulsive therapy."

If you do not wish to undergo ECT under any circumstances, you should initial the line next to "I do not consent to the administration of electroconvulsive therapy". **NOTE: Your agent MAY NOT consent to ECT unless you initial this authorization.**

#### d. Preferences for experimental studies

Opportunities may exist for you to participate in experimental studies related to treatment of your illness. Sometimes these studies provide more data that helps doctors determine the cause or best practice for treating an illness. Sometimes the studies are based on the idea that a certain new treatment might help. If you participate in a study, you may have access to a new treatment sooner than you would otherwise. However, there may be some level of risk involved. If you want to participate in a study because your doctor believes that the potential benefits to you outweigh the potential risks, you should initial the first choice.

If you do not want to participate in experimental studies of any kind, under any circumstances, you should initial the choice that states that you do not consent. **NOTE: Your agent MAY NOT consent to experimental studies unless you initial this authorization.**

#### e. Preferences regarding drug trials

Similarly, you may have the opportunity to participate in a trial related to new medications. If you participate, you may have access to a new drug sooner than you would otherwise. However, there may be risks or side effects. If you want to participate in a drug trial because your doctor believes that the potential benefits to you outweigh the potential risks, you should initial the first choice. If you do not want to participate in a drug trial of any kind, under any circumstances, you should initial the choice that states your agent does not have your authorization to consent on your behalf.

#### f. Additional instructions or information

One of the significant benefits of filling out an Advance Directive is that you are communicating important information to your doctor and people who support you.

This part of your form allows you to provide information that may or may not be directly related to your mental health treatment. If there is other information that you would like your doctor to know, you should include it here. You can attach an additional page to the form if there is not enough room to write everything you need to. Just be sure that you print or type your statements, and try to make them as clear as possible, to minimize confusion about what you want to happen. Again, if you do not have a preference about something listed, just leave that particular section blank.

#### E. Revocations and Amendments

Revocation means that you are canceling your Power of Attorney. If you revoke your Power of Attorney, your agent will no longer be representing you, and your doctor will no longer have to follow the instructions that your agent gives. You may change or revoke your Power of Attorney at any time, as long as you have capacity to make mental health decisions when you make the change or revocation. You may revoke a specific instruction without revoking the entire document.

If you are currently under an involuntary commitment, and you want to change or revoke your Power of Attorney, you will need to request an evaluation to determine if you are capable of making mental health decisions. The evaluation will be done by both a psychiatrist and another psychiatrist, psychologist, family physician, attending physician or other mental health professional. If you are found to have the capacity to make mental health decisions, you will be able to revoke or change your Power of Attorney, even though you are in the hospital.

You may revoke your Power of Attorney orally or in writing. It becomes effective as soon as you communicate your revocation to your treating doctor. It is best to make any changes or revocation in writing, because then there is a clear record of your wishes.

If you make a new Power of Attorney, you should be sure to notify your doctor and support people that you have revoked the old one. Your Power of Attorney will automatically expire two years from the date you made it, unless you are unable to

make mental health decisions for yourself at the time it would expire. In that case, it will remain in force until you are able to make decisions for yourself.

To amend your Power of Attorney means that you make changes to it. You may make changes at any time, as long as you have capacity to make mental health care decisions. Any changes must be made in writing and be signed and witnessed by two individuals in the same way as the original document. Any changes will be effective as soon as the changes are communicated to your attending physician or other mental health care provider, either by you, or a witness to your amendments.

#### F. Termination

Your Advance Directive will automatically expire two years from the date of execution, unless you have been found incapable of making mental health care decisions at the time the Directive would expire. In that case, the Directive will continue to be in force until you regain capacity.

#### G. Preference as to a court-appointed guardian

If you become incapacitated, it is possible that a court may appoint a guardian to act on your behalf. Under the guardianship laws, you may nominate a guardian of your person for consideration by the court. The court will appoint your guardian in accordance with your most recent nomination except for good cause or disqualification. If you wish to name someone in your Power of Attorney, it is important that you talk to that person about whether they feel they can serve as your guardian, because a court will not force them to serve. It is also important that you give that person a copy of your Power of Attorney and explain your wishes regarding mental health treatment.

If the court appoints a guardian, that person will not be able to terminate, revoke or suspend your Power of Attorney unless you want them to be able to. In this section, you should decide whether you want a court appointed guardian to have that power. Even if you do not specify a person that you would want as a guardian, you can still specify whether a person that is appointed by the court is allowed to terminate, revoke or suspend your Power of Attorney.

If the court appointed guardian and your agent turn out to be different people, the court will give preference to allowing your mental health care agent to continue making mental healthcare decisions as provided in your Directive, unless you specify otherwise in your Directive. If, after thorough examination, the court decides to grant the powers that you gave to an agent to the guardian, the guardian would still be bound by the same obligations that your agent would have been.

#### H. Execution

**You must sign and date your Mental Health Care Power of Attorney in this section.** If you are unable to sign for yourself, someone else may sign on your behalf. **Your document must be signed and dated by you in the presence of two witnesses.** Each witness must be at least 18 years old. If you are unable to sign the document yourself, you may have someone else sign on your behalf, but that person may not also be a witness.

In order for your Power of Attorney to be effective, you must be sure that the right people have access to it. Be sure to give copies of this to your mental health care provider, and anyone else that may be notified in the event that you are found not to have capacity to make mental health care decisions. Remember that if you cancel or change your document you must let everyone know. It is a good idea to carry a card in your wallet to let people know that you have a Power of Attorney.

**Please Note: The information in this document is not intended to constitute legal advice applicable to specific factual situations. For specific advice contact the Disabilities Law Project/Pennsylvania Protection & Advocacy (DLP/PP&A) intake line at 1-800-692-7443 (voice) or 1-877-375-7139 (TDD).**

## VI. GLOSSARY OF TERMS

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<b>Attending physician</b>	A physician who has primary responsibility for the treatment and care of the person making the Advance Directive.
<b>Agent</b>	An individual named by a person in a Mental Health Care Power of Attorney who will make mental health care decisions on behalf of the person.
<b>Amend</b>	To change or modify by adding or subtracting language.
<b>Declaration</b>	A writing which expresses a person's wishes and instructions for mental health care or other subjects.
<b>Execute</b>	To sign, date, and have the signature witnessed.
<b>Mental Health Advance Directive</b>	A document that allows a person to make choices regarding mental health treatment known in the event that the person is incapacitated by his/her mental illness. In effect, the person is giving or withholding consent to treatment before treatment is needed.
<b>Mental health care</b>	Any care, treatment, service or procedure to maintain, diagnose, treat, or provide for mental health, including any medication program and therapeutic treatment.
<b>Mental health care provider</b>	A person who is licensed, certified or otherwise authorized by the laws of Pennsylvania to provide mental health care.
<b>Mental health treatment professional</b>	A person trained and licensed in psychiatry, social work, psychology, or nursing who has a graduate degree and clinical experience.
<b>Power of Attorney</b>	A writing made by a person naming someone else to make mental health care decisions on behalf of the person.
<b>Revoke</b>	To cancel or end.

# Forms

Combined  
Declaration  
Power of Attorney

The following pages contain sample forms that can be torn out and used (or duplicated.) For more information on these please see the resources listed in the Introduction (p. 3). All forms have been provided as a courtesy from the Disabilities Law Project.



# COMBINED MENTAL HEALTH CARE DECLARATION AND POWER OF ATTORNEY FORM

## Part I. Introduction

I, \_\_\_\_\_, having capacity to make mental health decisions, willfully and voluntarily make this Declaration and Power of Attorney regarding my mental health care. I understand that mental health care includes any care, treatment, service or procedure to maintain, diagnose, treat or provide for mental health, including any medication program and therapeutic treatment. Electroconvulsive therapy may be administered only if I have specifically consented to it in this document. I will be the subject of laboratory trials or research only if specifically provided for in this document. Mental health care does not include psychosurgery or termination of parental rights. I understand that my incapacity will be determined by examination by a psychiatrist and one of the following: another psychiatrist, psychologist, family physician, attending physician or mental health treatment professional. Whenever possible, one of the decision makers will be one of my treating professionals.

### A. When this Combined Mental Health Declaration and Power of Attorney becomes effective

This Combined Mental Health Declaration and Power of Attorney becomes effective at the following designated time:

- When I am deemed incapable of making mental health care decisions. I would prefer the following doctor(s) to evaluate me for my ability to make mental health decisions:

Name of Doctor: \_\_\_\_\_

Address/Phone Number: \_\_\_\_\_

- When the following condition is met: (List condition) \_\_\_\_\_

### B. Revocation and Amendments

This Combined Mental Health Care Declaration and Power of Attorney may be revoked in whole or in part at any time, either orally or in writing, as long as I have not been found to be incapable of making mental health decisions. My revocation will be effective upon communication to my attending physician or other mental health care provider, either by me or a witness to my revocation, of the intent to revoke. If I choose to revoke a particular instruction contained in this Power of Attorney in the manner specified, I understand that the other instructions contained in this Power of Attorney will remain effective until:

- (1) I revoke this Power of Attorney in its entirety;
- (2) I make a new combined Mental Health Care Declaration and Power of Attorney; or
- (3) Two years from the date this document was executed.

I may make changes to this Advance Directive at any time, as long as I have capacity to make mental health care decisions. Any changes will be made in writing and be signed and witnessed by two individuals in the same way as the original document. Any changes will be effective as soon the changes are communicated to my attending physician or other mental health care provider, either by me, my agent, or a witness to my amendments.

### C. Termination

I understand that this Declaration will automatically terminate two years from the date of execution, unless I am deemed incapable of making mental health care decisions at the time that this Declaration would expire.

## Part II. Mental Health Declaration

### A. Treatment preferences

#### 1. Choice of treatment facility

- In the event that I require commitment to a psychiatric treatment facility, I would prefer to be admitted to the following facility:

Name of facility: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

- In the event that I require commitment to a psychiatric treatment facility, I do not wish to be committed to the following facility:

Name of facility: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

I understand that my physician may have to place me in a facility that is not my preference.

#### 2. Preferences regarding medications for psychiatric treatment

- I consent to the medications that my treating physician recommends.
- I consent to the medications that my treating physician recommends with the following exceptions, limitations, and/or preferences:

Medication	Reason for Exception
_____	_____
_____	_____
_____	_____

I consent to the following medications with these limitations:

Medication	Limitation	Reason for Limitation
_____	_____	_____
_____	_____	_____
_____	_____	_____

I prefer the following medications:

Medication	Reason for Preference
_____	_____
_____	_____
_____	_____

The exception, limitation, or preference, applies to generic, brand name and trade name equivalents unless otherwise stated. I understand that dosage instructions are not binding on my physician.

- I have designated an agent under the Power of Attorney portion of this document to make decisions related to medication.
- I do not consent to the use of any medications.

3. Preferences for electroconvulsive therapy (ECT)

- I consent to the administration of electroconvulsive therapy.
- I have designated an agent under the Power of Attorney portion of this document to make decisions related to electroconvulsive therapy.
- I do not consent to the administration of electroconvulsive therapy.

**4. Preferences for experimental studies**

- I consent to participation in experimental studies if my treating physician believes that the potential benefits to me outweigh the possible risks to me.
- I have designated an agent under the Power of Attorney portion of this document to make decisions related to experimental studies.
- I do not consent to participation in experimental studies.

**5. Preferences for drug trials.**

- I consent to participation in drug trials if my treating physician believes that the potential benefits to me outweigh the possible risks to me.
- I have designated an agent under the Power of Attorney portion of this document to make decisions related to drug trials.
- I do not consent to participation in any drug trials.

**6. Additional instructions or information.**

Examples of other instructions or information that may be included:

Activities that help or worsen symptoms:

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Type of intervention preferred in the event of a crisis:

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Mental and physical health history:

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Dietary requirements:

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Religious preferences:

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Temporary custody of children:

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Family notification:

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Limitations on the release or disclosure of mental health records:

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Temporary care and custody of pets:

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Other matters of importance:

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## Part III. Mental Health Care Power of Attorney

I, \_\_\_\_\_, having the capacity to make mental health decisions, authorize my designated health care agent to make certain decisions on my behalf regarding my mental health care. If I have not expressed a choice in this document or in the accompanying Declaration, 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.

### A. Designation of 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 authorization applies only to mental health decisions that are not addressed in the accompanying signed Declaration.

Name of designated person: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Agent's acceptance:

I hereby accept designation as mental health care agent for (insert name of declarant).

\_\_\_\_\_ .

Agent's signature: \_\_\_\_\_

Name of Agent: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### B. Designation of alternative agent

In the event that my first agent is unavailable or unable to serve as my mental health care agent, I hereby designate and appoint the following individual as my alternative mental health care agent to make mental health care decisions for me as authorized in this document:

Name of designated person: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Alternative Agent's acceptance:

I hereby accept designation as alternative mental health care agent for (insert name of declarant).

\_\_\_\_\_ .

Alternate Agent's signature: \_\_\_\_\_

Name of Alternate Agent: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### **C. Authority granted to my mental health care agent**

I hereby grant to my agent full power and authority to make mental health care decisions for me consistent with the instructions and limitations set forth in this document. If I have not expressed a choice in this Power of Attorney, or in the accompanying Declaration, 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. Preferences regarding medications for psychiatric treatment.**

- My agent is authorized to consent to the use of any medications after consultation with my treating psychiatrist and any other persons my agent considers appropriate.
- My agent is not authorized to consent to the use of any medications.

#### **2. Preferences regarding electroconvulsive therapy (ECT).**

- My agent is authorized to consent to the administration of electroconvulsive therapy.
- My agent is not authorized to consent to the administration of electroconvulsive therapy.

#### **3. Preferences for experimental studies.**

- My agent is authorized to consent to my participation in experimental studies if, after consultation with my treating physician and any other individuals my agent deems appropriate, my agent believes that the potential benefits to me outweigh the possible risks to me.
- My agent is not authorized to consent to my participation in experimental studies.

#### **4. Preferences regarding drug trials.**

- My agent is authorized to consent to my participation in drug trials if, after consultation with my treating physician and any other individuals my agent deems appropriate, my agent believes that the potential benefits to me outweigh the possible risks to me.
- My agent is not authorized to consent to my participation in drug trials.

## PART IV. Nominating a Guardian

### A. Preference as to a court-appointed guardian

I understand that I may nominate a guardian of my person for consideration by the court if incapacity proceedings are commenced under 20 Pa.C.S. § 5511. I understand that the court will appoint a guardian in accordance with my most recent nomination except for good cause or disqualification. In the event a court decides to appoint a guardian, I desire the following person to be appointed:

Name of Person: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

- The appointment of a guardian of my person will not give the guardian the power to revoke, suspend or terminate this Combined Mental Health Care Declaration and Power of Attorney.
- Upon appointment of a guardian, I authorize the guardian to revoke, suspend or terminate this Combined Mental Health Care Declaration and Power of Attorney.

## PART V. Execution

I am making this Combined Mental Health Care Declaration and Power of Attorney on the

\_\_\_\_\_ day of (month) \_\_\_\_\_, (year) \_\_\_\_\_.

My Signature: \_\_\_\_\_

My Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Witness Signature

Name of Witness: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Name of Witness: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

If the principal making this Combined Mental Health Care Declaration and Power of Attorney is unable to sign this document, another individual may sign on behalf of and at the direction of the principal. An agent or a person signing on behalf of the principal may not also be a witness.

Signature of person signing on my behalf: \_\_\_\_\_

Name of Person: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_



# MENTAL HEALTH CARE DECLARATION FORM

I, \_\_\_\_\_, having capacity to make mental health decisions, willfully and voluntarily make this Declaration regarding my mental health care. I understand that mental health care includes any care, treatment, service or procedure to maintain, diagnose, treat or provide for mental health, including any medication program and therapeutic treatment. Electroconvulsive therapy may be administered only if I have specifically consented to it in this document. I will be the subject of laboratory trials or research only if specifically provided for in this document. Mental health care does not include psychosurgery or termination of parental rights. I understand that my incapacity will be determined by examination by a psychiatrist and one of the following: another psychiatrist, psychologist, family physician, attending physician or mental health treatment professional. Whenever possible, one of the decision makers will be one of my treating professionals.

## A. When this Declaration becomes effective

This Declaration becomes effective at the following designated time:

- When I am deemed incapable of making mental health care decisions. I would prefer the following doctor(s) to evaluate me for my ability to make mental health decisions:

Name of Doctor: \_\_\_\_\_

Address/Phone Number: \_\_\_\_\_

- When the following condition is met: (List condition) \_\_\_\_\_

## B. Treatment preferences

1. Choice of treatment facility.

- In the event that I require commitment to a psychiatric treatment facility, I would prefer to be admitted to the following facility:

Name of facility: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

- In the event that I require commitment to a psychiatric treatment facility, I do not wish to be committed to the following facility:

Name of facility: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

I understand that my physician may have to place me in a facility that is not my preference.

2. Preferences regarding medications for psychiatric treatment.

- I consent to the medications that my treating physician recommends.
- I consent to the medications that my treating physician recommends with the following exceptions, limitations and/or preferences:

Medication	Reason for Exception
_____	_____
_____	_____
_____	_____

I consent to the following medications with these limitations:

Medication	Limitation	Reason for Limitation
_____	_____	_____
_____	_____	_____
_____	_____	_____

I prefer the following medications:

Medication	Reason for Preference
_____	_____
_____	_____
_____	_____

The exception, limitation, or preference, applies to generic, brand name and trade name equivalents unless otherwise stated. I understand that dosage instructions are not binding on my physician.

- I do not consent to the use of any medications.

3. Preferences regarding electroconvulsive therapy (ECT).

- I consent to the administration of electroconvulsive therapy.
- I do not consent to the administration of electroconvulsive therapy.

4. Preferences for experimental studies.

- I consent to participation in experimental studies if my treating physician believes that the potential benefits to me outweigh the possible risks to me.
- I do not consent to participation in experimental studies.

**5. Preferences for drug trials.**

- I consent to participation in drug trials if my treating physician believes that the potential benefits to me outweigh the possible risks to me.
- I do not consent to participation in any drug trials.

**6. Additional instructions or information.**

Examples of other instructions or information that may be included:

Activities that help or worsen symptoms:

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Type of intervention preferred in the event of a crisis:

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Mental and physical health history:

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Dietary requirements:

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Religious preferences:

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Temporary custody of children:

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Family notification:

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Limitations on the release or disclosure of mental health records:

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Temporary care and custody of pets:

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Other matters of importance:

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### **C. Revocation and Amendments**

This Declaration may be revoked in whole or in part at any time, either orally or in writing, as long as I have not been found to be incapable of making mental health decisions. My revocation will be effective upon communication to my attending physician or other mental health care provider, either by me or a witness to my revocation, of the intent to revoke. If I choose to revoke a particular instruction contained in this Declaration in the manner specified, I understand that the other instructions contained in this Declaration will remain effective until:

- (1) I revoke this Declaration in its entirety;
- (2) I make a new Mental Health Advance Directive; or
- (3) Two years after the date this document was executed.

I may make changes to this Advance Directive at any time, as long as I have capacity to make mental health care decisions. Any changes will be made in writing and be signed and witnessed by two individuals in the same way the original document was executed. Any changes will be effective as soon the changes are communicated to my attending physician or other mental health care provider, either by me or a witness to my amendments.

### **D. Termination**

I understand that this Declaration will automatically terminate two years from the date of execution, unless I am deemed incapable of making mental health care decisions at the time that this Declaration would expire.

### **E. Preference as to a court-appointed guardian**

I understand that I may nominate a guardian of my person for consideration by the court if incapacity proceedings are commenced under 20 Pa.C.S. § 5511. I understand that the court will appoint a guardian

in accordance with my most recent nomination except for good cause or disqualification. In the event a court decides to appoint a guardian, I desire the following person to be appointed:

Name of Person: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

- The appointment of a guardian of my person will not give the guardian the power to revoke, suspend or terminate this Declaration.
- Upon appointment of a guardian, I authorize the guardian to revoke, suspend or terminate this Declaration.

**F. Execution**

I am making this Declaration on the \_\_\_\_\_ day of (month) \_\_\_\_\_, (year) \_\_\_\_\_.

My Signature: \_\_\_\_\_

My Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Witness Signature

Name of Witness: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Name of Witness: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

If the principal making this Declaration is unable to sign it, another individual may sign on behalf of and at the direction of the principal.

Signature of person signing on my behalf: \_\_\_\_\_

Name of Person: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

# MENTAL HEALTH POWER OF ATTORNEY

I, \_\_\_\_\_, having the capacity to make mental health decisions, authorize my designated health care agent to make certain decisions on my behalf regarding my mental health care. 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.

I understand that mental health care includes any care, treatment, service or procedure to maintain, diagnose, treat or provide for mental health, including any medication program and therapeutic treatment. Electroconvulsive therapy may be administered only if I have specifically consented to it in this document. I will be the subject of laboratory trials or research only if specifically provided for in this document. Mental health care does not include psychosurgery or termination of parental rights.

I understand that my incapacity will be determined by examination by a psychiatrist and one of the following: another psychiatrist, psychologist, family physician, attending physician or mental health treatment professional. Whenever possible, one of the decision makers shall be one of my treating professionals.

## A. Designation of 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.

Name of designated person: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### Agent's acceptance:

I hereby accept designation as mental health care agent for (insert name of declarant).

\_\_\_\_\_

Agent's signature: \_\_\_\_\_

## B. Designation of alternative agent

In the event that my first agent is unavailable or unable to serve as my mental health care agent, I hereby designate and appoint the following individual as my alternative mental health care agent to make mental health care decisions for me as authorized in this document:

Name of designated person: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Alternative Agent's acceptance:**

I hereby accept designation as alternative mental health care agent for (insert name of declarant).

\_\_\_\_\_

Alternate Agent's signature: \_\_\_\_\_

**C. When this Power of Attorney becomes effective**

This Power of Attorney will become effective at the following designated time:

- When I am deemed incapable of making mental health care decisions. I would prefer the following doctor(s) to evaluate me for my ability to make mental health decisions:

Name of Doctor: \_\_\_\_\_

Address/Phone Number: \_\_\_\_\_

- When the following condition is met: \_\_\_\_\_

**D. Authority granted to my mental health care agent**

I hereby grant to my agent full power and authority to make mental health care decisions for me consistent with the instructions and limitations set forth in this Power of Attorney. If I have not expressed a choice in this Power of Attorney, 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. Treatment preferences.**

(a). Choice of treatment facility.

- In the event that I require commitment to a psychiatric treatment facility, I would prefer to be admitted to the following facility:

Name of facility: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

- In the event that I require commitment to a psychiatric treatment facility, I do not wish to be committed to the following facility:

Name of facility: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

I understand that my physician may have to place me in a facility that is not my preference.

**(b). Preferences regarding medications for psychiatric treatment.**

- I consent to the medications that my agent agrees to after consultation with my treating physician and any other persons my agent considers appropriate.



I consent to the medications that my agent agrees to, with the following exceptions or limitations:

Medication	Reason for Exception
_____	_____
_____	_____
_____	_____

I consent to the following medications with these limitations:

Medication	Limitation	Reason for Limitation
_____	_____	_____
_____	_____	_____
_____	_____	_____

The exception or limitation applies to generic, brand name and trade name equivalents unless otherwise stated. I understand that dosage instructions are not binding on my physician.

My agent is not authorized to consent to the use of any medications.

**(c). Preferences regarding electroconvulsive therapy (ECT).**

My agent is authorized to consent to the administration of electroconvulsive therapy.  
**NOTE: Your agent MAY NOT consent to ECT unless you initial this authorization.**

My agent is not authorized to consent to the administration of electroconvulsive therapy.

**(d). Preferences for experimental studies.**

My agent is authorized to consent to my participation in experimental studies if, after consultation with my treating physician and any other individuals my agent deems appropriate, my agent believes that the potential benefits to me outweigh the possible risks to me.  
**NOTE: Your agent MAY NOT consent to experimental studies unless you initial this authorization.**

My agent is not authorized to consent to my participation in experimental studies.

**(e). Preferences regarding drug trials.**

My agent is authorized to consent to my participation in drug trials if, after consultation with my treating physician and any other individuals my agent deems appropriate, my agent believes that the potential benefits to me outweigh the possible risks to me.  
**NOTE: Your agent MAY NOT consent to research including drug trials unless you initial this authorization.**

My agent is not authorized to consent to my participation in drug trials.

(f). Additional instructions or information.

Examples of other instructions or information that may be included:

Activities that help or worsen symptoms:

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Type of intervention preferred in the event of a crisis:

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Mental and physical health history:

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Dietary requirements:

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Religious preferences:

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Temporary custody of children:

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Family notification:

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Limitations on the release or disclosure of mental health records:

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Temporary care and custody of pets:

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Other matters of importance:

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### **E. Revocation and Amendments**

This Power of Attorney may be revoked in whole or in part at any time, either orally or in writing, as long as I have not been found to be incapable of making mental health decisions. My revocation will be effective upon communication to my attending physician or other mental health care provider, either by me or a witness to my revocation, of the intent to revoke. If I choose to revoke a particular instruction contained in this Power of Attorney in the manner specified, I understand that the other instructions contained in this Power of Attorney will remain effective until:

- (4) I revoke this Power of Attorney in its entirety;
- (5) I make a new combined Mental Health Care Declaration and Power of Attorney; or
- (6) Two years from the date this document was executed.

I may make changes to this Power of Attorney at any time, as long as I have capacity to make mental health care decisions. Any changes will be made in writing and be signed and witnessed by two individuals in the same way the original document was executed. Any changes will be effective as soon the changes are communicated to my attending physician or other mental health care provider, either by me, my agent, or a witness to my amendments.

### **F. Termination**

I understand that this Power of Attorney will automatically terminate two years from the date of execution unless I am deemed incapable of making mental health care decisions at the time that the Power of Attorney would expire.

### **G. Preference as to a court-appointed guardian**

I understand that I may nominate a guardian of my person for consideration by the court if incapacity proceedings are commenced under 20 Pa.C.S. § 5511. I understand that the court will appoint a guardian in accordance with my most recent nomination except for good cause or disqualification. In the event a court decides to appoint a guardian, I desire the following person to be appointed:

Name of Person: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

- The appointment of a guardian of my person will not give the guardian the power to revoke, suspend or terminate this Power of Attorney.
- Upon appointment of a guardian, I authorize the guardian to revoke, suspend or terminate this Power of Attorney.

## H. Execution

I am making this Mental Health Care Power of Attorney on the

\_\_\_\_\_ day of (month) \_\_\_\_\_, (year) \_\_\_\_\_.

Principle Signature: \_\_\_\_\_

Name of Principle: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Witness Signature

Name of Witness: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Name of Witness: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

If the principal making this Mental Health Care Power of Attorney is unable to sign this document, another individual may sign on behalf of and at the direction of the principal.

Signature of person signing on my behalf: \_\_\_\_\_

Name of Person: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

(additional space)

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(additional space)

**SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED**  
 To follow these orders, an EMS provider must have an order from his/her medical command physician



**Pennsylvania  
 Orders for Life-Sustaining  
 Treatment (POLST)**

Last Name
First/Middle Initial
Date of Birth

**FIRST** follow these orders, **THEN** contact physician, certified registered nurse practitioner or physician assistant. This is an Order Sheet based on the person's medical condition and wishes at the time the orders were issued. Everyone shall be treated with dignity and respect.

<b>A</b> Check One	<b>CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse <u>and</u> is not breathing.</b>
	<input type="checkbox"/> CPR/Attempt Resuscitation <input type="checkbox"/> DNR/Do Not Attempt Resuscitation (Allow Natural Death) When not in cardiopulmonary arrest, follow orders in <b>B, C</b> and <b>D</b> .

<b>B</b> Check One	<b>MEDICAL INTERVENTIONS: Person has pulse <u>and/or</u> is breathing.</b>
	<input type="checkbox"/> <b>COMFORT MEASURES ONLY</b> Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. <b>Do not transfer to hospital for life-sustaining treatment. Transfer if comfort needs cannot be met in current location.</b>
	<input type="checkbox"/> <b>LIMITED ADDITIONAL INTERVENTIONS</b> Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. <b>Transfer to hospital if indicated. Avoid intensive care if possible.</b>

**FULL TREATMENT** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.  
**Transfer to hospital if indicated. Includes intensive care.**

Additional Orders \_\_\_\_\_

<b>C</b> Check One	<b>ANTIBIOTICS:</b>	<b>D</b> Check One	<b>ARTIFICIALLY ADMINISTERED HYDRATION / NUTRITION:</b>
	<input type="checkbox"/> No antibiotics. Use other measures to relieve symptoms. <input type="checkbox"/> Determine use or limitation of antibiotics when infection occurs, with comfort as goal <input type="checkbox"/> Use antibiotics if life can be prolonged Additional Orders _____		Always offer food and liquids by mouth if feasible <input type="checkbox"/> No hydration and artificial nutrition by tube. <input type="checkbox"/> Trial period of artificial hydration and nutrition by tube. <input type="checkbox"/> Long-term artificial hydration and nutrition by tube. Additional Orders _____

<b>E</b> Check One	<b>SUMMARY OF GOALS, MEDICAL CONDITION AND SIGNATURES:</b>	
	Discussed with <input type="checkbox"/> Patient <input type="checkbox"/> Parent of Minor <input type="checkbox"/> Health Care Agent <input type="checkbox"/> Health Care Representative <input type="checkbox"/> Court-Appointed Guardian <input type="checkbox"/> Other:	<b>Patient Goals/Medical Condition:</b>

By signing this form, I acknowledge that this request regarding resuscitative measures is consistent with the known desires of, and in the best interest of, the individual who is the subject of the form.

Physician /PA/CRNP Printed Name:	Physician /PA/CRNP Phone Number
Physician/PA/CRNP Signature (Required):	DATE
Signature of Patient or Surrogate	
Signature (required)	Name (print)
Relationship (write "self" if patient)	

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Other Contact Information

Surrogate	Relationship	Phone Number	
Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

Directions for Healthcare Professionals

Any individual for whom a Pennsylvania Order for Life-Sustaining Treatment form is completed should ideally have an advance health care directive that provides instructions for the individual's health care and appoints an agent to make medical decisions whenever the patient is unable to make or communicate a healthcare decision. If the patient wants a DNR Order issued in section "A", the physician/PA/CRNP should discuss the issuance of an Out-of-Hospital DNR order, if the individual is eligible, to assure that an EMS provider can honor his/her wishes. Contact the Pennsylvania Department of Aging for information about sample forms for advance health care directives. Contact the Pennsylvania Department of Health, Bureau of EMS, for information about Out-of Hospital Do-Not-Resuscitate orders, bracelets and necklaces. POLST forms may be obtained online from the Pennsylvania Department of Health. [www.health.state.pa.us](http://www.health.state.pa.us)

Completing POLST

Must be completed by a health care professional based on patient preferences and medical indications or decisions by the patient or a surrogate. This document refers to the person for whom the orders are issued as the "individual" or "patient" and refers to any other person authorized to make healthcare decisions for the patient covered by this document as the "surrogate."

At the time a POLST is completed, any current advance directive, if available, must be reviewed.

Must be signed by a physician/PA/CRNP and patient/surrogate to be valid. Verbal orders are acceptable with follow-up signature by physician/PA/CRNP in accordance with facility/community policy. A person designated by the patient or surrogate may document the patient's or surrogate's agreement. Use of original form is strongly encouraged. Photocopies and Faxes of signed POLST forms should be respected where necessary

Using POLST

If a person's condition changes and time permits, the patient or surrogate must be contacted to assure that the POLST is updated as appropriate.

If any section is not completed, then the healthcare provider should follow other appropriate methods to determine treatment.

An automated external defibrillator (AED) should not be used on a person who has chosen "Do Not Attempt Resuscitation"

Oral fluids and nutrition must always be offered if medically feasible.

When comfort cannot be achieved in the current setting, the person, including someone with "comfort measures only," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).

A person who chooses either "comfort measures only" or "limited additional interventions" may not require transfer or referral to a facility with a higher level of care.

An IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only."

Treatment of dehydration is a measure which may prolong life. A person who desires IV fluids should indicate "Limited Additional Interventions" or "Full Treatment."

A patient with or without capacity or the surrogate who gave consent to this order or who is otherwise specifically authorized to do so, can revoke consent to any part of this order providing for the withholding or withdrawal of life-sustaining treatment, at any time, and request alternative treatment.

Review

This form should be reviewed periodically (consider at least annually) and a new form completed if necessary when:

- (1) The person is transferred from one care setting or care level to another, or
- (2) There is a substantial change in the person's health status, or
- (3) The person's treatment preferences change.

Revoking POLST

If the POLST becomes invalid or is replaced by an updated version, draw a line through sections A through E of the invalid POLST, write "VOID" in large letters across the form, and sign and date the form.