

PSYCHIATRIC ADVANCE DIRECTIVE

Directions for Using the Forms

How to Fill Out the Forms

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

How will anyone know I have an advance directive?

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

PHYSICIANS AND OTHERS PLEASE NOTE:

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

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

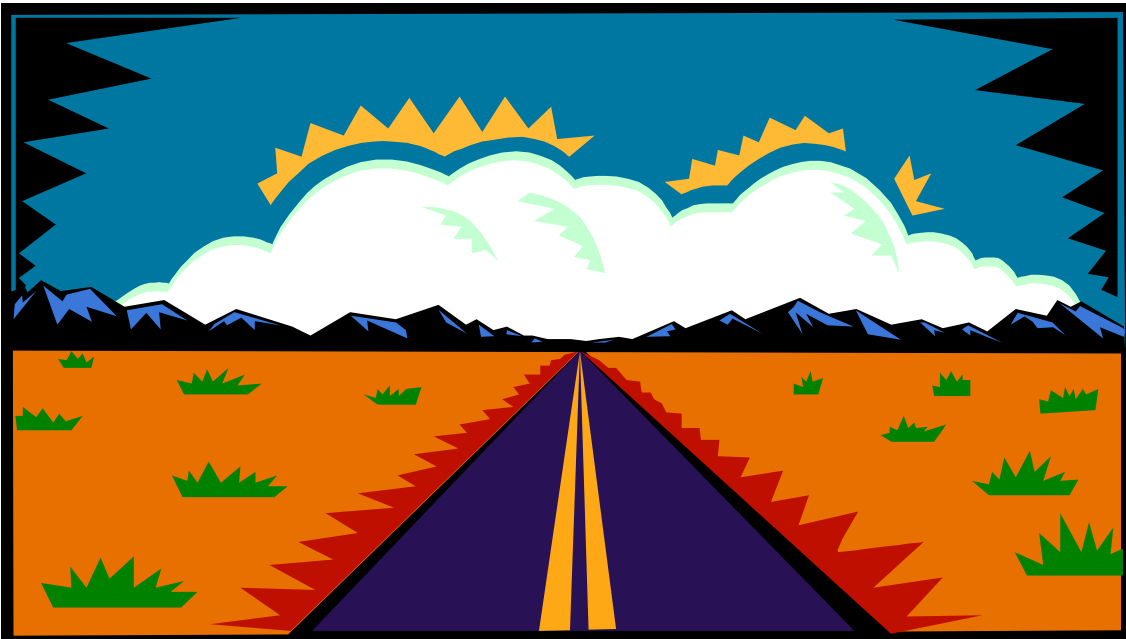
My name: _____ My SS#: _____

I have appointed as my agent for mental health decisionmaking:

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

MY TREATMENT MY CHOICES

Psychiatric Advance Directive of



Part I. Statement of Intent

I, _____, being of sound mind, willfully and voluntarily execute this psychiatric advance directive to assure that, during periods of incapacity resulting from psychiatric illness, my choices regarding my mental health care will be carried out despite my inability to make informed decisions on my own behalf. In the event that a guardian or other decisionmaker is appointed by a court to make mental health care decisions for me, I intend this document to take precedence over all other means of ascertaining my intent while competent.

By this document, I intend to create a psychiatric advance directive as authorized by MCL 700.5501 et seq, the U.S. Constitution and the Federal Patient Self-Determination Act of 1990 (P.L. 101-508) to indicate my wishes regarding mental health treatment. To the extent, if any, that this document is not valid under state law, it is my desire that it be considered a statement of my wishes and that it be accorded the greatest possible legal weight and respect. I understand that this directive will become active and take effect upon my incapacity to make my own mental health decisions and shall continue in effect only during that incapacity.

My wishes expressed in this document should be honored whether or not my patient advocate dies or withdraws. If I have not named a patient advocate, these instructions shall be binding upon whoever may be appointed as my agent or other decision maker.

The fact that I may have left blanks in this psychiatric advance directive (i.e., not completed certain sections) should not affect its validity in any way. I intend that all completed sections be followed. If I have not expressed a choice, my patient advocate should make the decision that he or she determines is the decision I would make if I were competent to do so.

If any part of this psychiatric advance directive is invalid or ineffective under relevant law, this fact should not affect the validity or effectiveness of the other parts. It is my intention that each part of this advance directive stand alone. Even if some parts are invalid or ineffective, I desire that all other parts be followed.

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

Instructions Included in My Psychiatric Advance Directive

Put a checkmark in the left-hand column for each section you have completed.

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

Part II. APPOINTMENT OF PATIENT ADVOCATE FOR MENTAL HEALTH CARE

Make sure you give your patient advocate a copy of all sections of this document

Statement of Intent to Appoint a Patient Advocate:

I, (your name) _____, being of sound mind, authorize a patient advocate to make certain decisions on my behalf regarding my mental health treatment when I lack the capacity to do so. I intend that those decisions should be made in accordance with my expressed wishes as set forth in this document. If I have not expressed a choice in this document, I authorize my patient advocate to make the decision that he or she determines is the decision I would make if I had the capacity to do so.

1. Designation of Patient Advocate For Mental Health Care

A. I hereby designate and appoint the following person as my patient advocate to make mental health care decisions for me as authorized in this document. This person is to be notified immediately of my admission to a psychiatric facility.

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

Name:

Address:

Day Phone Number _____

Night Phone Number _____

B. Patient Advocate's Acceptance: I hereby accept the designation as patient advocate for
(Your name)

As designated patient advocate, I understand the following:

1. This patient advocate designation is not effective unless the patient is unable to participate in mental health treatment decisions.
2. A patient advocate shall not exercise powers concerning the patient's care, custody, and medical or mental health treatment that the patient, if the patient were able to participate in the decision, could not have exercised on his or her own behalf.
3. A patient advocate shall not receive compensation for the performance of his or her authority, rights, and responsibilities, but a patient advocate may be reimbursed for actual and necessary expenses incurred in the performance of his or her authority, rights, and responsibilities.
4. A patient advocate shall act in accordance with the standards of care applicable to fiduciaries when acting for the patient and shall act consistent with the patient's best interests. The known desires of the patient expressed or evidenced while the patient is able to participate in medical treatment decisions are presumed to be in the patient's best interests.
5. A patient may revoke his or her patient advocate designation at any time and in any manner sufficient to communicate an intent to revoke.
6. A patient may waive his or her right to revoke the patient designation as to the power to make mental health treatment decisions, and if such a waiver is made, his or her ability to revoke as to certain treatment will be delayed for 30 days after the patient communicates his or her intent to revoke.
7. A patient advocate may revoke his or her acceptance of the patient advocate designation at any time and in any manner sufficient to communicate an intent to revoke.

Patient Advocate's Signature _____

Designation of Alternate Patient Advocate For Mental Health Care

If the person named above is unavailable or unable to serve as my patient advocate, I hereby appoint and desire immediate notification of my alternate patient advocate as follows:

Name:

Address:

Day Phone Number _____

Night Phone Number _____

Alternate Agent’s Acceptance: I hereby accept the designation as alternate patient advocate for

(Name) _____

As alternate patient advocate I understand 1. through 7. above

Alternate Patient Advocate’s Signature _____

The following paragraphs will apply when you appoint a patient advocate.

2. Authority Granted to My Agent

If I become incapable of giving consent to mental health care treatment, I hereby grant to my patient advocate full power and authority to make mental health care decisions for me, including the right to access confidential and privileged information about me and my treatment for the purpose of making informed decisions, to consent, refuse consent, or withdraw consent to any mental health care, treatment, service or procedure, consistent with any instructions and/or limitations I have set forth in this advance directive. If I have not expressed a choice in this advance directive, I authorize my patient advocate to make the decision that he or she determines is the decision I would make if I were competent to do so.

3. When Spouse Is Agent and If There Has Been a Legal Separation, Annulment, or Dissolution of the Marriage

Initial if you agree with this statement; leave blank if you do not.

_____ I desire the person I have named as my patient advocate, who is now my spouse, to remain as my patient advocate even if we become legally separated or our marriage is dissolved.

4. My Preference as to a Court-Appointed Guardian

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

Name: _____ Relationship: _____

Address:

City, State, Zip Code:

Day phone: _____ Evening Phone: _____

5. Powers of a Guardian

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

Part III. Statement Of My Desires, Instructions, Special Provisions And Limitations Regarding My Mental Health Treatment And Care

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

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

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

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

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

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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

Facility's Name: _____

Reason: _____

Facility's Name: _____

Reason: _____

Facility's Name: _____

Reason: _____

2. My Preferences Regarding Emergency Interventions

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

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

Reasons for my preference:

- _____ seclusion _____
- _____ physical restraints _____
- _____ seclusion and physical restraint
(combined) _____
- _____ medication by injection _____
- _____ medication in pill form _____
- _____ liquid medication _____
- _____ other: _____

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

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

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

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

A. _____ My choice of treating physician is:

Dr. _____

Phone number _____

OR

Dr. _____

Phone number _____

OR

Dr. _____

Phone number _____

B. _____ I do not wish to be treated by the following, for the reasons stated:

Dr. _____

Reason: _____

Dr. _____

Reason: _____

Dr. _____

Reason: _____

4. My Preferences Regarding Medications for Psychiatric Treatment

*In this section, you may choose any of the paragraphs A-G that you wish to apply. **Be sure to initial***

those you choose.

If it is determined that I do not have the capacity to consent to or to refuse medications relating to my mental health treatment, my wishes are as follows:

A. _____ I consent to the medications agreed to by my patient advocate, after consultation with my treating physician and any other individuals my agent may think appropriate, with the reservations, if any, described in (D) below.

B. _____ I consent to and authorize my patient advocate to consent to the administration of:

Medication Name	Not to exceed the following dosage:	OR	In such dosage as determined by
_____	_____		Dr. _____
_____	_____		Dr. _____
_____	_____		Dr. _____
_____	_____		Dr. _____

C. _____ I consent to the medications deemed appropriate by Dr. _____,

whose address and phone number are: _____

D. _____ I specifically do *not* consent and I do *not* authorize my patient advocate to consent to the administration of the following medications or their respective brand-name, trade-name or generic equivalents:

Name of Drug	Reason for Refusal
_____	_____
_____	_____
_____	_____

Name of Drug	Reason for Refusal
_____	_____
_____	_____

E. ____ I am willing to take the medications excluded in (D) above if my only reason for excluding them is their side effects and the dosage can be adjusted to eliminate those side effects.

F. ____ I am concerned about the side effects of medications and do **not** consent or authorize my patient advocate consenting to any medication that has any of the side effects I have checked below at a 1% or greater level of incidence (*check all that apply*).

- | | |
|-------------------------------|-------------------------------------|
| ____ Tardive dyskinesia | ____ Tremors |
| ____ Loss of sensation | ____ Nausea/vomiting |
| ____ Motor restlessness | ____ Neuroleptic Malignant Syndrome |
| ____ Seizures | ____ Other _____ |
| ____ Muscle/skeletal rigidity | |

G. ____ I have the following other preferences about psychiatric medications:

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

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

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

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

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

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

OR

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

OR

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

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

Part IV. Statement Of My Preferences Regarding Notification Of Others, Visitors, And Custody Of My Child(ren)

1. Who Should Be Notified Immediately of My Admission to a Psychiatric Facility

If I am incompetent, I desire staff to notify the following individuals immediately that I have been admitted to a psychiatric facility:

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Address: _____ Address: _____

Phone (Day): _____ Phone (Day): _____

Phone (Eve.): _____ Phone (Eve.): _____

It is also my desire that this person be permitted to visit me: Yes _____ No _____

It is also my desire that this person be permitted to visit me: Yes _____ No _____

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Address: _____ Address: _____

Phone (Day): _____ Phone (Day): _____

Phone (Eve.): _____ Phone (Eve.): _____

It is also my desire that this person be permitted to visit me: Yes _____ No _____

It is also my desire that this person be permitted to visit me: Yes _____ No _____

2. Who Should Be Prohibited from Visiting Me

I do not wish the following people to visit me while I am receiving care in a psychiatric facility:

Name

Relationship

3. My Preferences for Care & Temporary Custody of My Children

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

Name: _____ Relationship: _____

Address:

City, State,

Zip: _____

Phone number: (Day) _____

(Evening) _____

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

My Second Choice

Name: _____

Relationship: _____

Address: _____

Phone (Day): _____

My Third Choice

Name: _____

Relationship: _____

Address: _____

Phone (Day): _____

Phone (Eve.): _____ Phone (Eve.): _____

Part V. Statement Of My Preferences Regarding Revocation Or Termination of This Advance Directive

Initial all paragraphs that you wish to apply to you.

1. Revocation of My Psychiatric Advance Directive

_____My wish is that this psychiatric advance directive may be revoked, suspended or terminated by me at any time. I realize this may result in involuntary mental health treatment.

2. Waiver of My Right to Revoke My Psychiatric Advance Directive

_____ My wish is that I waive my right to revoke this psychiatric advance directive during any period of my incapacity. HOWEVER, mental health treatment provided to me should I indicate an intent to revoke during a period of incapacity SHALL NOT continue for more than 30 consecutive days. This waiver does not affect my right to give written notice of intent to terminate my voluntary hospitalization under Section 419 of the Michigan Mental Health Code.

2A. _____ Notwithstanding the above, it is my wish that my patient advocate or other decision-maker specifically ask me about my preferences before making a decision regarding mental health care, and take the preferences I express here into account when making such a decision, even while I am incompetent or incapacitated.

3. Other Instructions About Mental Health Care

(Use this space to add any other instructions that you wish to have followed. If you need to, add pages, numbering them as part of this section.)

4. Duration of Mental Health Care Directive

Initial A or B.

A. _____ It is my intention that this advance directive will remain in effect for an indefinite period of time. OR

B. _____ It is my intention that this advance directive will automatically expire two years from the date it was executed.

Part VI. Signature Page

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

Your Signature

Date

The directive above was signed and declared by the "Declarant,"
(*youname*) _____ ,
to be his/her psychiatric care advance directive, in our presence who, at his/her request,
have signed names below as witness. We declare that, at the time of the execution of this
instrument, the Declarant, according to our best knowledge and belief, was of sound mind
and under no constraint or undue influence. We further declare that none of us is: 1) a
physician; 2) the Declarant's physician or an employee of the Declarant's physician; 3) an
employee or a patient of any residential health care facility in which the Declarant is a
patient; 4) designated as patient advocate or alternate under this document; or 5) a
beneficiary or creditor of the estate of the Declarant.

Dated at _____ (*county, state*),
this _____ day of _____, 20____.

Witness Signatures

Witness 1:

Witness 2:

Signature of Witness 1

Signature of Witness 2

Name of Witness 1 (printed)

Name of Witness 2 (printed)

Home address of Witness 1

Home address of Witness 2

City, State, Zip Code of Witness 1

City, State, Zip Code of Witness 2

(For use by the notary):

State of _____, County of

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

_____,

and (*names of witnesses*)

_____ and

_____,

witnesses, as the voluntary act and deed of the Declarant, this

_____ day of _____, _____.

My commission expires:

Notary Public

Record of Psychiatric Advance Directive

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

My name _____ My health care agent's name _____

My address _____ My health care agent's address _____

My date of birth _____ My health care agent's telephone number(s) _____

I have given copies of this form to:

Name _____ Address or phone _____

Name _____ Address or phone _____

Name _____ Address or phone _____

Name _____ Address or phone _____

Name _____ Address or phone _____

Name _____ Address or phone _____

Name _____ Address or phone _____