Writing an Advance Directive

A. Directions for Using the Forms

If you are reading this online, print or download the sections you plan to use.
How to fill out the forms
Frequently Asked Questions
Forms to Prepare an Advance Psychiatric Directive (browser-friendly HTML version)
Forms to Prepare an Advance Psychiatric Directive (printer-friendly PDF version)*
* You will need the free Acrobat Reader to view and print the PDF file.

I. How to Fill Out the Forms

Read each section carefully.

Choose which sections you wish to use. Sections I and VI are required. If you aren't sure whether or not you want to use section II, appointing an agent, find out if your state's law requires an agent for mental health decision making. Your state protection and advocacy agency may be able to tell you. Sections III, IV and V are optional and cover the substance of your instructions.

If you decide to appoint an agent, make sure he or she understands your wishes and is willing to take the responsibility. Your agent and alternate agent(s) should sign the form to show acceptance of the responsibility.

Talk over your choices with your treating providers and your case manager.
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).

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
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.

Complete the checklist attached to section I to show at a glance what your advance directive covers.

Assemble the completed sections, renumber the pages and sign section VI before two witnesses (see the list on the signature page of people who cannot be your witness). Some states may require a notary's signature as well; if you are not sure, it's best to have the document notarized.

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

II. Frequently Asked Questions

Can I change my mind?

You can revise your advance directive at any time unless you have been declared legally incompetent. However, state laws vary about whether you may revoke your advance directive or overrule your own agent after becoming incapacitated. Part V spells out some options describing when you want to be able to revoke, suspend or end this advance directive. A lawyer can explain your state's law in this regard. (Note that only a few states have any specific law on this. As of 1997, Alaska, Hawaii, Illinois, Maine, Minnesota, North Carolina, Oklahoma, Oregon, South Dakota, Utah and West Virginia do.)
Should I see a mental health professional before signing an advance directive?
For your advance directive to be valid, you must be legally competent when you sign it. To protect yourself against any claim that you were not competent when you signed your advance directive, you can ask a mental health professional to conduct a mental status exam and note in your medical record file that you were of sound mind at the time. Ask for a signed copy of this note, and attach it to your advance directive. This is not absolutely necessary, but it can head off future challenges.

What to do when you are finished?

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

When will my advance directive take effect?

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

Who should have copies?

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

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

How will anyone know I have an advance directive?

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

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

_____

_____

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

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

Part I. Statement of Intent

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

By this document, I intend to create an advance directive for health care as authorized by state law, the U.S. Constitution and the Federal Patient Self-Determination Act of 1990 (P.L. 101-508) to indicate my wishes regarding mental health treatment. To the extent, if any, that this document is not valid under state law, it is my desire that it be considered a statement of my wishes and that it be accorded the greatest possible legal weight and

respect. I understand that this directive will become active and take effect upon my incapacity to make my own mental health decisions and shall continue in effect only during that incapacity.

My wishes expressed in this document should be honored whether or not my agent dies or withdraws or if I have no agent appointed at the time of the execution of this document. If I have not named an agent, these instructions shall be binding upon whomever may be appointed as my agent or other decisionmaker.

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

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

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

Note to Provider: The next page is a checklist of the sections I have completed. Failure to follow the instructions in these sections (or the requests of my agent), even in emergency situations, may result in legal liability for professional misconduct and/or battery. I include this statement to express my strong desire for you to acknowledge and abide by my rights, under state and federal laws, to influence decisions about the care I will receive.

Instructions Included in My Directive
Put a checkmark in the 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).

____ Consent for experimental studies or drug trials.

____ Who should be notified immediately of my admission to a psychiatric facility.

____ Who should be prohibited from visiting me.

____ My preferences for care and temporary custody of my children.

____ My preferences about revocation of my health care directive during a period of incapacity.

____ Other instructions about mental health care.

____ Duration of this mental health care directive.

Part II. Appointment Of Agent For Mental Health Care

Make sure you give your agent a copy of all sections of this document.

Statement of Intent to Appoint an Agent:

I, (your name)_____, being of sound mind, authorize a health care agent to make certain decisions on my behalf regarding my mental health treatment when I am incompetent to do so. I intend that those decisions should be made in accordance with my expressed wishes as set forth in this document. If I have not expressed a choice in this document, I authorize my agent to make the decision that my agent determines is the decision I would make if I were competent to do so.

1. **Designation of Mental Health Care Agent**
   A. I hereby designate and appoint the following person as my agent to make mental health care decisions for me as authorized in this document. This person is to be notified immediately of my admission to a psychiatric facility.

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

Name:

_____

Address:

_____

_____

Day Phone Number _____ Night Phone

_____

B. Agent's Acceptance: I hereby accept the designation as agent for
(your name)

_____

(your agent's
signature)_____

Designation of Alternate Mental Health Care Agent
If the person named above is unavailable or unable to serve as my agent, I hereby appoint and desire immediate notification of my alternate agent as follows:

Name:

_____

Address:

_____

_____

Day Phone Number _____ Night Phone

_____

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

Alternate Agent's Acceptance: I hereby accept the designation as alternate agent for
(your
name)_____
(Your agent's
signature)_____

The following paragraphs will apply when you appoint an agent.

2. Authority Granted to My Agent

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

A. _____ If I become incapable of giving consent to mental health care treatment, I hereby grant to my agent full power and authority to make mental health care decisions for me, including the right to consent, refuse consent, or withdraw consent to any mental

health care, treatment, service or procedure, consistent with any instructions and/or limitations I have set forth in this advance directive. If I have not expressed a choice in this advance directive, I authorize my agent to make the decision that my agent determines is the decision I would make if I were competent to do so.

B._____ Having named an agent to act on my behalf, I do, however, wish to be able to discharge or change the person who is to be my agent if that agent is instrumental in the process of initiating or extending any period of psychiatric treatment against my will. My ability to revoke or change agents in this circumstance shall be in effect even while I am incompetent or incapacitated, if allowed by law. Even if I choose to discharge or replace my agent, all other provisions of this advance directive shall remain in effect and shall only be revokable or changeable by me at a time when I am considered competent and capable of making informed health care decisions.

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

Initial if you agree with this statement; leave blank if you do not.
_____ I desire the person I have named as my agent, who is now my spouse, to remain as my agent even if we become legally separated or our marriage is dissolved.

4. My Preference as to a Court-Appointed Guardian

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

Name:_____

Relationship:_____

Address:
_____

City, State, Zip Code:
_____

Day phone: _____ Evening Phone:_____

5. Powers of a Guardian
The appointment of a guardian of my estate or my person or any other decision maker shall not give the guardian or decision maker the power to revoke, suspend, or terminate this directive or the powers of my agent, except as specifically required by law.
Make sure you give your agent a copy of all sections of this document.

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

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

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

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

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

_____
_
_____
_
_____
_
_____
_
_____
_
_____
_
_____
_
_____
_

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

_____
_
_____
_
_____
_
_____
_
_____
_
_____
_
_____
_
_____
_

C. _____ I do ***not*** wish to be committed to the following hospitals or programs/facilities for psychiatric care for the reasons I have listed:
Facility's Name:_____
Reason: _____
Facility's Name: _____
Reason:_____
Facility's Name: _____
Reason:_____

2. My Preferences Regarding Emergency Interventions
If, during an admission or commitment to a mental health treatment facility, it is determined that I am engaging in behavior that requires an emergency intervention (e.g., seclusion and/or physical restraint and/or medication), my wishes regarding which form of emergency interventions should be made are as follows. I prefer these interventions in the following order:
Fill in numbers, giving 1 to your first choice, 2 to your second, and so on until each has a number. If an intervention you prefer is not listed, write it in after "other" and give it a number as well.

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

Reasons for my preferences:
_____
_
_____
_
_____
_
_____
_
_____
_
_____
_
_____
_

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

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

_____ _____

OR _

Dr. _____

_____ _

Phone number Dr.

_____ _____

OR Reason:_____

Dr. _

_____ _____

Phone number _

_____ _____

_

4. My Preferences Regarding Medications for Psychiatric Treatment

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

If it is determined that I am not legally competent to consent to or to refuse medications relating to my mental health treatment, my wishes are as follows:

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

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

Medication Name	**Not to exceed the following dosage:**	**OR**	**In such dosage(s) as determined by**
_____ _	_____ _		Dr._____ _
_____ _	_____ _		Dr._____ _
_____ _	_____ _		Dr._____ _
_____ _	_____ _		Dr._____ _

C._____ I consent to the medications deemed appropriate by Dr._____, whose address and phone number are:

_____

_____

_____

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

name or generic equivalents:

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 agent to consent to any medication that has any of the side effects I have checked below at a 1% or greater level of incidence (*check all that apply*).

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

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

_____
_____
_____
_____
_____
_____

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

If it is determined that I am not legally capable of consenting to or refusing

electroconvulsive therapy, my wishes regarding electroconvulsive therapy are as follows:
Initial A or B; if you 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 agent to consent, to the administration of electroconvulsive therapy, but only:
B1. _____with the number of treatments that the attending psychiatrist deems appropriate;
OR
B2. _____ with the number of treatments that Dr. _____ deems appropriate. Phone number and address of doctor:
_____
_____
_____
OR
B3. _____for no more than the following number of ECT treatments: _____

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

6. Consent for Experimental Studies or Drug Trials
Initial one of the following paragraphs.

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

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

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

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

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

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

Name:_______________________________
_
Relationship: __________________________
Address:
____
____
_
____
_
Phone (Day):___________________________
Phone (Eve.):
____
It is also my desire that this person be permitted to visit me: Yes_____ No _____

Name:_______________________________
_
Relationship: __________________________
Address:
____
____
_
____
_
Phone (Day):___________________________
Phone (Eve.):
____
It is also my desire that this person be permitted to visit me: Yes_____ No _____

Name:_______________________________
_
Relationship: __________________________
Address:
____
____
_
____
_
Phone (Day):___________________________
Phone (Eve.):
____
It is also my desire that this person be permitted to visit me: Yes_____ No _____

Name:_______________________________
_
Relationship: __________________________
Address:
____
____
_
____
_
Phone (Day):___________________________
Phone (Eve.):
____
It is also my desire that this person be permitted to visit me: Yes_____ No _____

2. Who Should Be Prohibited from Visiting Me

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

Name	**Relationship**
____	______________________________
__	__
____	______________________________
__	__
____	______________________________

__ __
_____ _____
__ __
_____ _____
__ __
_____ _____
__ __

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

In the event that I am unable to care for my child(ren), 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):_____
Phone (Eve.):
_____

My Third Choice
Name:_____
_
Relationship: _____
Address:
_____
_____
_
_____
_
Phone
(Day):_____
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 mental health directive may be revoked, suspended or terminated by me at any time, if state law so permits.

2. Revocation of My Psychiatric Advance Directive During a Period of Incapacity

_____ My wish is that this mental health care directive may be revoked, suspended or terminated by me only at times that I have the capacity and competence to do so. I understand that I may be choosing to give up the right to change my mind at any time. I expressly give up this right to ensure compliance with my advance directive. My decision not to be able to change this advance directive while I am incompetent or incapacitated is made to ensure that my previous, carefully considered thoughts about how I want to be treated will remain in effect during the time I am incompetent or incapacitated.

2A. _____ Notwithstanding the above, it is my wish that my agent or other decisionmaker 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.)

_____
_____
_____
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4. Duration of Mental Health Care Directive
Initial A or B.

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

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

If my choice above is not valid under state law, then it is my intention that this advance directive remain in effect for as long as the law permits.

Part VI. Signature Page

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

_____ _____

Your Signature *Date*

The directive above was signed and declared by the "Declarant," (*your name*) _____ _____ , to be his/her mental health care advance directive, in our presence who, at his/her request, have signed names below as witness. We declare that, at the time of the execution of this instrument, the Declarant, according to our best knowledge and belief, was of sound mind and under no constraint or undue influence. We further declare that none of us is: 1) a physician; 2) the Declarant's physician or an employee of the Declarant's physician; 3) an employee or a patient of any residential health care facility in which the Declarant is a patient; 4) designated as agent or alternate under this document; or 5) a beneficiary or creditor of the estate of the Declarant.
Dated at _____ (*county, state)*, this _____ day of _____, 19____.

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