NOTICE TO PERSONS
CREATING A MENTAL HEALTH ADVANCE DIRECTIVE

This is an important legal document. It creates an advance directive for mental health treatment. Before signing this document you should know these important facts:

(1) This document is called an advance directive and allows you to make decisions in advance about your mental health treatment, including medications, short-term admission to inpatient treatment and electroconvulsive therapy.

YOU DO NOT HAVE TO FILL OUT OR SIGN THIS FORM.

IF YOU DO NOT SIGN THIS FORM, IT WILL NOT TAKE EFFECT.

If you choose to complete and sign this document, you may still decide to leave some items blank.

(2) You have the right to appoint a person as your agent to make treatment decisions for you. You must notify your agent that you have appointed him or her as an agent. The person you appoint has a duty to act consistently with your wishes made known by you. If your agent does not know what your wishes are, he or she has a duty to act in your best interest. Your agent has the right to withdraw from the appointment at any time.
(3) The instructions you include with this advance directive and the authority you give your agent to act will only become effective under the conditions you select in this document. You may choose to limit this directive and your agent's authority to times when you are incapacitated or to times when you are exhibiting symptoms or behavior that you specify. You may also make this directive effective immediately. No matter when you choose to make this directive effective, your treatment providers must still seek your informed consent at all times that you have capacity to give informed consent.
(4) You have the right to revoke this document in writing at any time you have capacity.

YOU MAY NOT REVOKE THIS DIRECTIVE WHEN YOU HAVE BEEN FOUND TO BE INCAPACITATED UNLESS YOU HAVE SPECIFICALLY STATED IN THIS DIRECTIVE THAT YOU WANT IT TO BE REVOCABLE WHEN YOU ARE INCAPACITATED.

(5) This directive will stay in effect until you revoke it unless you specify an expiration date. If you specify an expiration date and you are incapacitated at the time it expires, it will remain in effect until you have capacity to make treatment decisions again unless you chose to be able to revoke it while you are incapacitated and you revoke the directive.
(6) You cannot use your advance directive to consent to civil commitment. The procedures that apply to your advance directive are different than those provided for in the Involuntary Treatment Act. Involuntary treatment is a different process.
(7) If there is anything in this directive that you do not understand, you should ask a lawyer to explain it to you.

(8) You should be aware that there are some circumstances where your provider may not have to follow your directive.
(9) You should discuss any treatment decisions in your directive with your provider.
(10) You may ask the court to rule on the validity of your directive.

PART I.

STATEMENT OF INTENT TO CREATE A MENTAL HEALTH ADVANCE DIRECTIVE

I, _____, being a person with capacity, willfully and voluntarily execute this mental health advance directive so that my choices regarding my mental health care will be carried out in circumstances when I am unable to express my instructions and preferences regarding my mental health care. If a guardian is appointed by a court to make mental health decisions for me, I intend this document to take precedence over all other means of ascertaining my intent.

The fact that I may have left blanks in this directive does 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 in my best interest. I intend this directive to take precedence over any other directives I have previously executed, to the extent that they are inconsistent with this document, or unless I expressly state otherwise in either document.

I understand that I may revoke this directive in whole or in part if I am a person with capacity. I understand that I cannot revoke this directive if a court, two health care providers, or one mental health professional and one health care provider find that I am an incapacitated person, unless, when I executed this directive, I chose to be able to revoke this directive while incapacitated.

I understand that, except as otherwise provided in law, revocation must be in writing. I understand that nothing in this directive, or in my refusal of treatment to which I consent in this directive, authorizes any health care provider, professional person, health care facility, or agent appointed in this directive to use or threaten to use abuse, neglect, financial exploitation, or abandonment to carry out my directive. I understand that there are some circumstances where my provider may not have to follow my directive.

PART II.

WHEN THIS DIRECTIVE IS EFFECTIVE YOU MUST COMPLETE THIS PART FOR YOUR DIRECTIVE TO BE VALID.

I intend that this directive become effective (YOU MUST CHOOSE ONLY ONE):
_____ Immediately upon my signing of this directive.
_____ If I become incapacitated.

_____ When the following circumstances, symptoms, or behaviors occur:
_____

PART III.
DURATION OF THIS DIRECTIVE YOU MUST COMPLETE THIS PART FOR YOUR DIRECTIVE TO BE VALID.

I want this directive to (YOU MUST CHOOSE ONLY ONE):
_____ Remain valid and in effect for an indefinite period of time.
_____ Automatically expire _____ years from the date it was created.

PART IV.

WHEN I MAY REVOKE THIS DIRECTIVE YOU MUST COMPLETE THIS PART FOR THIS DIRECTIVE TO BE VALID.

I intend that I be able to revoke this directive (YOU MUST CHOOSE ONLY ONE):
_____ Only when I have capacity.

I understand that choosing this option means I may only revoke this directive if I have capacity. I further understand that if I choose this option and become incapacitated while this directive is in effect, I may receive treatment that I specify in this directive, even if I object at the time.
_____ Even if I am incapacitated.

I understand that choosing this option means that I may revoke this directive even if I am incapacitated. I further understand that if I choose this option and revoke this directive while I am incapacitated I may not receive treatment that I specify in this directive, even if I want the treatment.

PART V.

PREFERENCES AND INSTRUCTIONS ABOUT TREATMENT, FACILITIES, AND PHYSICIANS OR PSYCHIATRIC ADVANCED REGISTERED NURSE PRACTITIONERS

A. Preferences and Instructions About Physician(s) or Psychiatric Advanced Registered Nurse Practitioner(s) to be Involved in My Treatment
I would like the physician(s) or psychiatric advanced registered nurse practitioner(s) named below to be involved in my treatment decisions:

Dr. or PARNP _____
Contact information: _____

Dr. or PARNP _____

Contact information: _____

I do not wish to be treated by Dr. or PARNP _____

B. Preferences and Instructions About Other Providers
I am receiving other treatment or care from providers who I feel have an impact on my mental health care. I would like the following treatment provider(s) to be contacted when this directive is effective:

Name _____ Profession _____
Contact information _____

Name _____ Profession _____
Contact information _____

C. Preferences and Instructions About Medications for Psychiatric Treatment
(initial and complete all that apply)

_____ I consent, and authorize my agent (if appointed) to consent, to the following medications: _____
_____ I do not consent, and I do not authorize my agent (if appointed) to consent, to the administration of the following medications: _____
_____ I am willing to take the medications excluded above if my only reason for excluding them is the side effects which include _____ and these side effects can be eliminated by dosage adjustment or other means.
_____ I am willing to try any other medication the hospital doctor or psychiatric advanced registered nurse practitioner recommends
_____ I am willing to try any other medications my outpatient doctor or psychiatric advanced registered nurse practitioner recommends
_____ I do not want to try any other medications.

Medication Allergies

_____I have allergies to, or severe side effects from, the following: _____
_____ FORMTEXT
_____

Other Medication Preferences or Instructions

_____ I have the following other preferences or instructions about medications:
_____

D. Preferences and Instructions About Hospitalization and Alternatives

(initial all that apply and, if desired, rank "1" for first choice, "2" for second choice, and so on)

_____ 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 prefer to receive this care in programs/facilities designed as alternatives to psychiatric hospitalizations.
_____ I would also like the interventions below to be tried before hospitalization is considered:
_____ Calling someone or having someone call me when needed.
Name: _____ Telephone: _____
_____ Staying overnight with someone
Name: _____ Telephone: _____
_____ Having a mental health service provider come to see me
_____ Going to a crisis triage center or emergency room
_____ Staying overnight at a crisis respite (temporary) bed
_____ Seeing a service provider for help with psychiatric medications
_____ Other, specify: _____

Authority to Consent to Inpatient Treatment

I consent, and authorize my agent (if appointed) to consent, to voluntary admission to inpatient mental health treatment for _____ days (not to exceed 14 days)
(Sign one):
_____ If deemed appropriate by my agent (if appointed) and treating physician or psychiatric advanced registered nurse practitioner:
_____(Signature)

or

_____ Under the following circumstances (specify symptoms, behaviors, or circumstances that indicate the need for hospitalization) _____
_____
_____(Signature)
_____ I do not consent, or authorize my agent (if appointed) to consent, to inpatient treatment
_____(Signature)

Hospital Preferences and Instructions

If hospitalization is required, I prefer the following hospitals:_____
_____

I do not consent to be admitted to the following hospitals:_____
_____

E. Preferences and Instructions About Preemergency

I would like the interventions below to be tried before use of seclusion or restraint is considered

(initial all that apply):

_____ "Talk me down" one-on-one
_____ More medication
_____ Time out/privacy
_____ Show of authority/force
_____ Shift my attention to something else
_____ Set firm limits on my behavior
_____ Help me to discuss/vent feelings
_____ Decrease stimulation
_____ Offer to have neutral person settle dispute
_____ Other, specify _____

F. Preferences and Instructions About Seclusion, Restraint, and Emergency Medications

If it is determined that I am engaging in behavior that requires seclusion, physical restraint, and/or emergency use of medication, I prefer these interventions in the order I have chosen (choose "1" for first choice, "2" for second choice, and so on):

_____ Seclusion
_____ Seclusion and physical restraint (combined)
_____ Medication by injection
_____ Medication in pill or liquid form

In the event that my attending physician or psychiatric advanced registered nurse practitioner decides to use medication in response to an emergency situation after due consideration of my preferences and instructions for emergency treatments stated above, I expect the choice of medication to reflect any preferences and instructions I have expressed in Part III C of this form. The preferences and instructions I express in this section regarding medication in emergency situations do not constitute consent to use of the medication for non-emergency treatment.

G. Preferences and Instructions About Electroconvulsive Therapy (ECT or Shock Therapy)

My wishes regarding electroconvulsive therapy are (sign one):

_____ I do not consent, nor authorize my agent (if appointed) to consent, to the administration of electroconvulsive therapy
_____(Signature)

_____ I consent, and authorize my agent (if appointed) to consent, to the administration of electroconvulsive therapy
_____(Signature)

_____ I consent, and authorize my agent (if appointed) to consent, to the administration of electroconvulsive therapy, but only under the following conditions:_____
_____(Signature)

H. Preferences and Instructions About Who is Permitted to Visit

If I have been admitted to a mental health treatment facility, the following people are not

permitted to visit me there:
Name: _____
Name: _____
Name: _____
I understand that persons not listed above may be permitted to visit me.

I. Additional Instructions About My Mental Health Care
Other instructions about my mental health care: _____

In case of emergency, please contact:
Name: _____ Address: _____
Work telephone: _____ Home telephone: _____
Physician or psychiatric advanced registered nurse practitioner:
_____ Address: _____
Telephone: _____

The following may help me to avoid a hospitalization:
_____

I generally react to being hospitalized as follows:
_____

Staff of the hospital or crisis unit can help me by doing the following:
_____

J. Refusal of Treatment
I do not consent to any mental health treatment.
_____(Signature)

PART VI.

DURABLE POWER OF ATTORNEY (APPOINTMENT OF MY AGENT)

(Fill out this part only if you wish to appoint an agent or nominate a guardian.)

I authorize an agent to make mental health treatment decisions on my behalf. The authority granted to my agent includes 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 directive. 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 **and my agent does not otherwise know my wishes**, I authorize my agent to make the decision that my agent determines is in my best interest. This agency shall not be affected by my incapacity. Unless I state otherwise in this durable power of attorney, I may revoke it unless prohibited by other state law.

A. Designation of an Agent

I appoint the following person as my agent to make mental health treatment decisions for me as authorized in this document and request that this person be notified immediately when this directive becomes effective:

Name: _____ Address: _____
Work telephone: _____ Home telephone: _____
Relationship: _____

B. Designation of Alternate Agent

If the person named above is unavailable, unable, or refuses to serve as my agent, or I revoke that person's authority to serve as my agent, I hereby appoint the following person as my alternate agent and request that this person be notified immediately when this directive becomes effective or when my original agent is no longer my agent:

Name: _____ Address: _____
Work telephone: _____ Home telephone: _____
Relationship: _____

C. When My Spouse is My Agent (initial if desired)

_____ If my spouse is my agent, that person shall remain my agent even if we become legally separated or our marriage is dissolved, unless there is a court order to the contrary or I have remarried.

D. Limitations on My Agent's Authority

I do not grant my agent the authority to consent on my behalf to the following:

_____

E. Limitations on My Ability to Revoke this Durable Power of Attorney

I choose to limit my ability to revoke this durable power of attorney as follows:

_____

F. Preference as to Court-Appointed Guardian

In the event a court appoints a guardian who will make decisions regarding my mental health treatment, I nominate the following person as my guardian:

Name: _____ Address: _____
Work telephone: _____ Home telephone: _____
Relationship: _____

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 authorized by law.

_____
(Signature required if nomination is made)

PART VII.
OTHER DOCUMENTS

(Initial all that apply)

I have executed the following documents that include the power to make decisions regarding health care services for myself:

_____ Health care power of attorney (chapter 11.94 RCW)
_____ "Living will" (Health care directive; chapter 70.122 RCW)
_____ I have appointed more than one agent. I understand that the most recently appointed agent controls except as stated below:
_____

PART VIII.
NOTIFICATION OF OTHERS AND CARE OF PERSONAL AFFAIRS

(Fill out this part only if you wish to provide nontreatment instructions.)

I understand the preferences and instructions in this part are NOT the responsibility of my treatment provider and that no treatment provider is required to act on them.

A. Who Should Be Notified

I desire my agent to notify the following individuals as soon as possible when this directive becomes effective:

Name: _____ Address: _____
Day telephone: _____ Evening telephone: _____
Name: _____ Address: _____
Day telephone: _____ Evening telephone: _____

B. Preferences or Instructions About Personal Affairs

I have the following preferences or instructions about my personal affairs (e.g., care of dependents, pets, household) if I am admitted to a mental health treatment facility:

_____
_____ FORMTEXT
_____

C. Additional Preferences and Instructions:

_____
_____

PART IX.

SIGNATURE

By signing here, I indicate that I understand the purpose and effect of this document and that I am giving my informed consent to the treatments and/or admission to which I have consented or authorized my agent to consent in this directive. I intend that my consent in this directive be construed as being consistent with the elements of informed consent under chapter 7.70 RCW.

Signature: _____ Date: _____
Printed Name: _____

This directive was signed and declared by the "Principal," to be his or her directive, in our presence who, at his or her request, have signed our names below as witnesses. We declare that, at the time of the creation of this instrument, the Principal is personally

known to us, and, according to our best knowledge and belief, has capacity at this time and does not appear to be acting under duress, undue influence, or fraud. We further declare that none of us is:

(A) A person designated to make medical decisions on the principal's behalf;

(B) A health care provider or professional person directly involved with the provision of care to the principal at the time the directive is executed;

(C) An owner, operator, employee, or relative of an owner or operator of a health care facility or long-term care facility in which the principal is a patient or resident;

(D) A person who is related by blood, marriage, or adoption to the person, or with whom the principal has a dating relationship as defined in RCW 26.50.010;

(E) An incapacitated person;

(F) A person who would benefit financially if the principal undergoes mental health treatment;

or

(G) A minor.

Witness 1: Signature: _____ Date: _____
Printed Name: _____ Telephone: _____
Address: _____

Witness 2: Signature: _____ Date: _____
Printed Name: _____ Telephone: _____
Address: _____

PART X.
RECORD OF DIRECTIVE

I have given a copy of this directive to the following persons: _____
_____

DO NOT FILL OUT PART XI UNLESS YOU INTEND TO REVOKE THIS DIRECTIVE IN PART OR IN WHOLE

PART XI.
REVOCATION OF THIS DIRECTIVE

(Initial any that apply):

_____ I am revoking the following part(s) of this directive (specify): _____
_____ I am revoking all of this directive.

By signing here, I indicate that I understand the purpose and effect of my revocation and that no person is bound by any revoked provision(s). I intend this revocation to be interpreted as if I had never completed the revoked provision(s).

Signature: _____ Date: _____
Printed Name: _____

DO NOT SIGN THIS PART UNLESS YOU INTEND TO REVOKE THIS DIRECTIVE IN PART OR IN WHOLE