PSYCHIATRIC ADVANCE DIRECTIVE

(Wyoming Statutes 35-22-302)

I, _____ being over eighteen years of age and of sound mind, willfully and voluntarily make known my desires regarding the use of psychiatric restabilization measures.

I understand that "psychiatric restabilization" means measures to restore mental function or to support mental health in the event of destabilization of mental health due to lack of appropriate treatment. Psychiatric restabilization measures include administration of prescribed liquid medication by mouth or injection, administration of prescribed medication orally, physical restraint, seclusion or crisis psychiatric counseling.

It is my desire that psychiatric restabilization measures

_____ be used in treatment for me.

_____ NOT BE USED IN TREATMENT FOR ME.

Signed this the _____ day of _____, 20_____.

Signature: _____

Printed Name: _____

Date of Birth: _____ Sex: _____

Hair Color: _____ Eye Color: _____

Race/Ethnic Background: _____

Social Security Number: _____

Sponsoring Facility/Institution of Enrollment (if applicable):

_____

Signature of Attending Physician/Psychiatric Personnel:

_____

Printed Name of Attending Physician/Psychiatric Personnel:

_____

Address of Attending Physician/Psychiatric Personnel:

_____

Telephone Number of Attending Physician/Psychiatric Personnel:

_____