Mental Health Advance Directive

If you believe you may be hospitalized for mental health care in the future and that your doctor may think you aren't able to make good decisions about your treatment, then completing a mental health advance directive will ensure that your treatment choices are known. It is important that you decide NOW what types of treatment you do or do not want and to appoint a friend or family member to make the mental health care decisions that you want carried out. You may always change your preferences or surrogate later.

C

You can use the following Advance Directive form to direct your future care.

- Read each section of the form carefully and talk about your choices with someone you trust.
- The person you choose to be your health care surrogate and alternate must be a competent adult whose civil rights have not been taken away. The person you choose should not be a mental health professional, an employee of a facility that might provide services to you, or an employee of the Department of Children & Family Services.
- You should sign the form in front of two witnesses.
- Make sure your surrogate understands your wishes and is willing to accept the responsibility. Your surrogate (and a back-up alternate surrogate if you wish) should sign this form now or at a later time to show they are aware you have chosen them to be your surrogate.
- Have copies made and give them to your surrogate, your case manager, your doctor, the hospital or crisis unit at which you are most likely be treated, your family and anyone else who might be involved in your care. Discuss your choices with each of them.
- The document should be available quickly if you need it. If you travel, be sure to take a copy with you.

Your advance directive will not take effect unless a physician decides that you are not competent to make your own treatment decisions. If you are in a psychiatric facility on an involuntary basis, you will have an attorney appointed to represent your interests and a hearing will be conducted in front of a judge or magistrate. A health care surrogate is not authorized to consent to treatment for a person on voluntary status.

I, _____, being of sound mind, willfully and voluntarily execute this mental health advance directive to assure that if I should be found incompetent to consent to my own mental health treatment, my choices regarding my treatment will be carried out despite my inability to make informed decisions for myself.

If a guardian, guardian advocate or other decision maker is appointed by a court to make health care or mental health decisions for me, I intend this document to take precedence over all other means of determining my intent while competent. This document represents my wishes, and it should be given the greatest possible legal weight and respect. If the surrogate(s) named in this directive are not available, my wishes shall be binding on whoever is appointed to make such decisions.

If I become incompetent to make decisions about my own mental health treatment, I have authorized a mental health care surrogate to make certain treatment decisions for me. My surrogate is also authorized to apply for public benefits to defray the cost of my health care, to release information to appropriate persons and to authorize my transfer from a health care facility.

My mental health care surrogate is:

Name: _____

Address: _____

Day Telephone: _____ Evening Telephone: _____

If the person named above is unable or unavailable to serve as my mental health care surrogate, I hereby appoint and request immediate notification of my alternate mental health care surrogate as follows:

Name of Alternate: _____

Address: _____

Day Telephone: _____ Evening Telephone: _____

Complete the following or Initial in the blank marked yes or no:

A. If I become incompetent to give consent to mental health treatment, I give my mental health care surrogate full power and authority to make mental health care decisions for me. This 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 stated in this advance directive. If I have not expressed a choice in this advance directive, I authorize my surrogate to make the decision that (s)he determines is the decision I would make if I were competent to do so. _____Yes ____No

B. My choices of treatment facilities are as follows:

1. In the event my psychiatric condition is serious enough to require 24-hour care, I would prefer to receive this care in this/these facilities:

   Facility: _____ Facility: _____

2. I do not wish to be admitted to the following facilities for psychiatric care (optional):

   Facility: _____ Facility: _____

C. My choice of a treating physician is:

First choice of physician: _____ Second choice of physician: _____

I <u>do not</u> wish to be treated by the following physicians: (optional)

Name of physician: _____ Name of Physician: _____

D. My wishes about confidentiality of my admission to a facility and my treatment while there are as follows:

1. My representative may be notified of my involuntary admission ___ Yes ___ No
2. Any person who seeks to contact me while I am in a facility may be told I am there. __ Yes __ No
3. I consent to release of information about my condition and treatment plan ___ Yes ___ No

   To the following persons: _____ _____

   _____ _____

   _____ _____

4. If I am incompetent to give consent, I want staff to immediately notify the following persons that I have been admitted to a psychiatric facility.

   Name: _____ Relationship: _____

   Address: _____

   Day Phone: _____ _____Evening Phone: _____

   Name: _____ Relationship: _____

   Address: _____

   Day Phone: _____ Evening Phone: _____

E. If I am not competent to consent to my own treatment or to refuse medications relating to my mental health treatment, I have initialed one of the following, which represents my wishes:

1. _____I wish to take the medications that Dr. _____ recommends.
2. _____I wish to take the medications agreed to by my mental health care surrogate after consulting with my treating physician and any other individuals my surrogate deems appropriate, with the exceptions found in #3 below.
3. _____I specifically do not wish to take and I do not authorize my mental health care surrogate to consent to the administration of the following medications or their respective brand name, trade name or generic equivalents: (list name of drug):_____
   _____
   _____
4. _____I am willing to take the medications excluded in #3 above if my only reason for excluding them is their side effects and the dosage can be adjusted to eliminate those side effects.
5. I have the following other preferences about psychiatric treatment and medications: _____
   _____
   _____
   _____

F. Florida law prohibits a mental health care surrogate from consenting to experimental treatments that have not been approved by a federally approved institutional review board without my prior written consent or the express approval of the court.

_____ I wish to participate in experimental drug studies or drug trials

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

G. My wishes regarding Electroconvulsive Therapy (ECT) are as follows:

1 _____My surrogate may not consent to ECT without express court approval.

2. _____I authorize my surrogate to consent to ECT, but only (initial one of the following):

   a. _____ with the number of treatments the attending psychiatrist thinks is appropriate; OR

   b. _____ with the number of treatments that Dr. _____ thinks is appropriate; OR

   c. _____for no more than the following number of ECT treatments: _____.

3. Other instructions and wishes regarding ECT are as follows: _____ _____
   _____
   _____

H. I ____have / ____ have not attached to this advance directive a Personal Safety Plan, regarding my preferences.

I. Other instructions I wish to make about my mental health care are (use additional pages if needed): _____
_____
_____
_____**Check here ( ) if other pages are used**

Signature

By signing here I indicate that I fully understand that this advance directive will permit my mental health care surrogate to make decisions and to provide, withhold or withdraw consent for my mental health treatment.

Printed Name (Declarant): _____
Signature: _____Date: _____

Witnesses

This advance directive was signed by _____ in our presence. At his/her request, we have signed our names below as witnesses. We declare that, at the time this advance directive was signed, the Declarant, according to our best knowledge and belief, was of sound mind and under no constraint or undue influence. We further declare that we are both adults, are not designated in this advance directive as the mental health care surrogate, and at least one of us is neither the person's spouse nor blood relative.

Dated at _____ This _____day of _____, _____.
(County & State) (Day) (Month) (Year)

Witness 1:	Witness 2:
_____	_____
Signature of witness 1	Signature of witness 2
_____	_____
Printed name of witness 1	Printed name of witness 2
_____	_____
Address of witness 1	Address of witness 2
_____	_____
City, State, Zip Code of witness 1	City, State, Zip Code of witness 2

Acknowledgement of Health Care Surrogate/Alternate

I, _____, mental health care surrogate designated by _____
_____, hereby accept the designation.

_____ _____
(Signature of Mental Health Care Surrogate) (Date)

I, _____, alternate mental health care surrogate designated by
_____, hereby accept the designation.

_____ _____
(Signature of Alternate Mental Health Care Surrogate) (Date)