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, completion of a mental health advance directive will help make your treatment preferences 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 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 your case manager, doctor, or other trusted persons.
- The person you choose to be your health care surrogate and alternate must be a competent person who is at least 18 years old, whose civil rights have not been taken away. The person you choose should **not** be a mental health professional, an employee of a facility which might provide services to you, an employee of the Department of Children & Family Services, or a member of the Local Advocacy Council.
- Make sure your surrogate understands your wishes and is willing to take the responsibility.
- You and your surrogate (and a back-up alternate surrogate if you wish) should sign the form in front of two witnesses.
- 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 taken, your family, and anyone else who might be involved in your care. Discuss your choices with each of them.

You can change your advance directive at anytime you are competent to do so. If you travel, be sure to take a copy of the advance directive with you. Your advance directive will not take effect unless a physician decides that you are incompetent to make your own treatment decisions. If you are in a psychiatric facility, you will have an attorney appointed to represent your interests, and will have a hearing in front of a judge or hearing master. 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 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: _____

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

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

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

Name of Alternate: _____
Address: _____
Day Telephone: _____ Evening Telephone: _____

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

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

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 my surrogate determines is the decision I would make if I were competent to do so. _____Yes ____No

B. My choice 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 placed in the following facilities for psychiatric care for the reasons I have listed:
   Facility/Reason: _____
   Facility/Reason: _____

C. My choice of a treating physician is:
   First choice of physician: _____
   Second choice of physician: _____

   I do not wish to be treated by the following physicians:
   Name of physician: _____
   Name of physician: _____

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D. My wishes regarding 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. _____I do <u>not</u> consent to the release of information about my admission or treatment to anyone unless I give specific consent at the time of the request or as otherwise allowed by law. ___Yes ___No

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 consent to the medications that Dr. _____ recommends.

2. _____ I consent to the medications agreed to by my mental health care surrogate, after consulting with my treating physician and any other individuals my surrogate may think appropriate, with the exceptions found in #3 below.

3. _____ I specifically do not consent 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 and reason for refusal
   _____
   _____

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 medications:
   _____
   _____

F. 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.

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

G. If, during a stay in a psychiatric facility, my behavior requires an emergency intervention, my wishes regarding which form of emergency interventions should be made 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.

___Seclusion
___ Physical restraints
___ Both seclusion and physical restraints
___ Other: ___ _____
___ _____

___ Medication in pill form
___ Medication in liquid medication
___ Medication by injection
___ _____
___ _____

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H. 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 consent to my participation in experimental drug studies or drug trials
_____ I do not wish to participate in experimental drug studies or drug trials

I. 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: _____

J. Other instructions I wish to make about my mental health care are (use additional pages if needed):
_____

_____

_____

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: _____

This advance directive was signed by _____ in our presence. At his/her request, we have signed our names below as witness. 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 Signatures:

Witness 1:

_____
Signature of witness 1

_____
Printed name of witness 1

_____
Home address of witness 1

_____
City, State, Zip Code of witness 1

Witness 2:

_____
Signature of witness 2

_____
Printed name of witness 2

_____
Home address of witness 2

_____
City, State, Zip Code of witness 2