Mental Health Care Treatment Decisions Advance Directive - Optional Form
§ 24-7B-1

§ 24-7B-7. Optional form for advance directive for mental health treatment

A. The form provided in Subsection E of this section may be used to create an individual instruction regarding mental health treatment. An individual may complete or modify all or any part of the form. The Mental Health Care Treatment Decisions Act governs the effect of this or any other writing used to create an advance directive for mental health treatment.

E. An advance directive for mental health treatment may be executed by using the following optional form, completed or modified to the extent desired by the individual, and the form may be notarized:

§ 24-7B-14. Effect of copy

A copy of a written advance directive for mental health treatment or revocation of an advance directive for mental health treatment has the same effect as the original.

ADVANCE DIRECTIVE FOR MENTAL HEALTH TREATMENT

I, _____, being a person with capacity, willfully and voluntarily make known my wishes about mental health treatment, by my instructions to others through my advance directive for mental health treatment, or by my appointment of an agent, or both. If a guardian or an agent is appointed to make mental health decisions for me, I intend this document to take precedence over other means of ascertaining my wishes and interests.

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. I intend this directive to take precedence over any other mental health 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 one qualified health care professional and one mental health treatment provider find that I am an incapacitated person, unless I successfully challenge the determination of incapacity.

I understand there are some circumstances where my provider may not have to follow my directive, specifically, if the treatment requested in this directive is infeasible or unavailable, the facility or provider is not licensed or authorized to provide the treatment requested or the directive conflicts with other applicable law.

I thus do hereby declare:

I. DECLARATION FOR MENTAL HEALTH TREATMENT

If a mental health treatment provider and a qualified health care professional, one of whom is my primary health care professional, if reasonably available, determine that my ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that I lack the capacity to refuse or consent to mental health treatment and that mental health treatment is necessary, I direct my primary health care professional and a mental health treatment provider, pursuant to the Mental Health Care Treatment Decisions Act, to provide the mental health treatment I have indicated below by my signature.

I understand that “mental health treatment” means services provided for the prevention of, amelioration of symptoms of or recovery from mental illness or emotional disturbance, including but not limited to electroconvulsive treatment, treatment with medication, counseling, rehabilitation services or evaluation for admission to a facility for care or treatment of persons with mental illness, if required. Preferences and Instructions About Treatment, Facilities and Physicians

I would like the physician(s) named below to be involved in my treatment decisions:

Dr. _____ Contact information _____

Dr. _____ Contact information _____

I do not wish to be treated by Dr. _____

Other Preferences: _____

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 _____

Preferences and Instructions About Medications for Mental Health Treatment (*initial and complete all that apply*)

___ I consent, and authorize my agent to consent, to the following medications: _____

___ I do not consent, and I do not authorize my agent 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 medications the hospital doctor recommends.

___ I am willing to try any other medications my outpatient doctor recommends.

___ I do not want to try any other medications.

Medication Allergies

I have allergies to, or severe side effects from, the following:

I have the following other preferences or instructions about medications:

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 hospitalization.

_____ 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: _____

___ 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 provider for help with psychiatric medications

___ Other, specify:

_____ Authority to Consent to Inpatient Treatment

I consent, and authorize my agent to consent, to evaluation for admission to inpatient mental health treatment.

(Sign one)

___ If deemed appropriate by my agent and treating physician

_____ 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 to consent, to evaluation for admission to inpatient treatment

_____ Signature

Preferences and Instructions About Use of Seclusion or Restraint

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 _____

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 my physician 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 this directive. The preferences and instructions I have expressed in this section regarding medication in emergency situations do not constitute consent to use of the medication for nonemergency treatment.

Preferences and Instructions About Electroconvulsive Therapy My wishes regarding electroconvulsive therapy are (*sign one*):

___ I do not consent, nor authorize my agent to consent, to the administration of electroconvulsive therapy.

_____ Signature

___ I consent, and authorize my agent to consent, to the administration of electroconvulsive therapy.

_____ Signature

___ I consent, and authorize my agent to consent, to the administration of electroconvulsive therapy, but only under the following conditions:

_____ Signature

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.

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: _____ 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: _____

Refusal of Treatment

I do not consent to any mental health treatment.

_____ Signature

I further state that this document and the information contained in it may be released to any requesting licensed mental health professional.

_____ _____

Signature of principal Date

_____ _____

Signature of witness Date

II. APPOINTMENT OF AGENT

If my primary health care professional and a mental health provider determine that my ability to receive and evaluate information

information effectively or communicate decisions is impaired to such an extent that I lack the capacity to refuse or consent to mental health treatment and that mental health treatment is necessary, I direct my primary health care professional and other health care providers, pursuant to the Mental Health Care Treatment Decisions Act, to follow the instructions of my agent.

I hereby appoint:

Name _____

Address _____

Telephone _____ to act as my agent to make decisions regarding my mental health treatment if I become incapable of giving or withholding informed consent for that treatment.

If the person named above refuses or is unable to act on my behalf, or if I revoke that person's authority to act as my agent, I authorize the following person to act as my agent:

Name _____

Address _____

Telephone _____

My agent is authorized to make decisions that are consistent with the wishes I have expressed in my declaration. If my wishes are not expressed, my agent is to act in what he or she believes to be my best interest.

_____ _____

Signature of principal Date

III. CONFLICTING PROVISION

I understand that if I have completed both a declaration and have appointed an agent and if there is a conflict between my agent's decision and my declaration, my declaration shall take precedence unless I indicate otherwise.

_____ Signature

I understand that if I have completed both an advance health care directive and an advance directive for mental health treatment, that those directives should be executed as separate instructions.

_____ Signature

IV. OTHER PROVISIONS

1. In the absence of my ability to give directions regarding my mental health treatment, it is my intention that this advance directive for mental health treatment shall be honored as the expression of my legal right to consent or to refuse to consent to mental health treatment.

2. I direct the following concerning the care of my minor children:

3. This advance directive for mental health treatment shall be in effect until it is revoked.

4. I understand that I may revoke this advance directive for mental health treatment at any time.

5. I understand and agree that if I have any prior advance directives for mental health treatment, and if I sign this advance directive for mental health treatment, my prior advance directives for mental health treatment are revoked.

6. I understand the full importance of this advance directive for mental health treatment and I am emotionally and mentally competent to make this advance directive for mental health treatment.

Signed this _____ day of _____, 20 ___

_____ Signature

_____ City, county and state of residence

This advance directive was signed in my presence.

_____ Signature of witness

_____ Address

_____".