PART 1: Statement of Intent to Create a Mental Health Advance Directive

I have completed this Psychiatric Advance Directive with much thought and with a sound mind. This document gives my mental health treatment choices and preferences, and/or appoints a Mental Health Care Agent or Durable Health Care Power of Attorney to speak for me if I cannot communicate or make my own mental health care decisions. My Mental Health Care Agent, if named, is able to make mental health decisions for me, including the decision to refuse treatments that I do not want.

This document will replace any previous mental health advance directive.

My name: _____ Date _____
My date of birth: _____
My address: _____
My telephone numbers: (home) _____ (cell) _____

☐ My initials here indicate a professional medical interpreter helped me complete this document.

PART 2: My Mental Health Care Agent

Also known as Durable Power of Attorney

If I cannot communicate my wishes and mental health care decisions due to illness or injury, or if my health care team determines that I cannot make my own mental health care decisions, I choose the person named below to communicate my wishes and make my mental health care decisions.

My Health Care Agent must:

- Follow my health care instructions in this document.
- Follow any other health care instructions I have given to him or her.
- Make decisions in my best interest and in accordance with accepted medical standards.

Requirements for who may be an Agent or Health Care Power of Attorney under State Law
Iowa: My agent cannot be a health care provider caring for me on the date I sign this document. My agent also cannot be an employee of a health care provider unless related to me by blood, marriage, or adoption within the third degree of relation.
Minnesota: My agent must be an adult. My agent cannot be a health care provider or employee of a health care provider giving me direct care unless I am related to that person by blood or marriage, registered domestic partnership, or adoption or unless I have specified otherwise in this document. (Specify here: _____)
In addition, a person appointed to determine my capacity to make decisions cannot be my agent.
North Dakota: My agent must be an adult. My agent cannot be: 1) my health care provider;
2) someone who is an employee of my health care provider but is not related to me; 3) my long term care services provider; or 4) someone who is an employee of my long term care services provider but is not related to me.
South Dakota: My agent must be an adult.

My primary (main) agent is:
Name:_____

Address:_____
_____

Telephone Numbers (H) _____(C)_____(W)_____

If my primary agent is not willing, able, or reasonable available to make mental health care decisions for me, I choose an alternate Mental Health Care Agent.

My alternate agent Is:
Name:_____
Address:_____
_____

Telephone Numbers (H) _____(C)_____(W)_____

Powers of my Health Care Agent:
My Mental Health Care Agent automatically has all the following powers when I do not have the capacity to make decisions and/or I am unable to communicate for myself:
A. Agree to, refuse, or cancel decisions about my mental health care. This includes medications, and other decisions related to treatments. If treatment has already begun, my agent can continue it or stop it based on my instructions.
B. Interpret any instruction in this document based on his or her understanding of my wishes, values and beliefs.
C. Review and release my medical records and personal files as needed for my health care, as stated in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
D. Arrange for my health care and treatment in a location he or she thinks is appropriate.
E. Decide which health care providers and organizations provide my health care.
Comments or limits on the above:

If I live in North Dakota or Minnesota, my initials below indicate I also authorize my Mental Health Care Agent to:
_____Continue as my agent even if our marriage or domestic partnership is legally ending or has been ended.
_____Make mental health care decisions for me even if I am able to decide or speak for myself, if I so choose.

My Preference of a Court-Appointed Guardian

If a court decides to appoint a guardian who will make decisions about my mental health treatment, my wishes are that the following person be considered.

Name: _____

Relationship: _____

Address:_____

City, State, Zip Code: _____

Telephone Numbers (H) _____(C)_____(W)_____

PART 3: My Mental Health Care Instructions

1. My preferences about hospitalization and choice of treatment facilities

A. _____ If I am to be **admitted to a hospital** for 24-hour care, I would **prefer** to receive care at **the following hospitals**:

Facility's Name: _____

Reason: _____

Facility's Name: _____

Reason: _____

B. _____ I would prefer to not be committed or hospitalized at the following programs/facilities for psychiatric care for the reasons I have listed:

Facility's Name: _____

Reason: _____

Facility's Name: _____

Reason: _____

I understand that my preferences will be honored when possible, but that circumstances may mean that I be treated at a facility that does not follow my preferences stated above.

2. My preferences regarding emergency treatment

If, during an admission or commitment to a mental health treatment facility, it is determined that I am engaging in behavior that requires an emergency intervention, I direct that the following interventions may not be performed on me:

Intervention or treatment:_____

Reason: _____

Intervention or treatment:_____

Reason: _____

3. My preferences about medications for psychiatric treatment

In this section, you may choose any of the paragraphs A-G that you wish to apply. Be sure to initial those you choose.

If it is determined that I am not legally competent to agree to or to refuse medications relating to my mental health treatment, my wishes are as follows:

A. _____ I consent to the medications agreed to by my agent. My agent may wish to speak with my treating physician and other persons before making a decision. See my reservations, if any, in (D) below.

B. _____ My current care team consists of the providers below. I would appreciate coordination with the following providers for medication management when possible.

C. _____ I request that the medications listed below not be used in my treatment. Consider the reasons for refusal of the following medications when making my treatment plan. I understand that my medical condition may mean that my refusal cannot be honored.

Name of Drug Reason for Refusal
Medication _____ Reason for Refusal _____
Medication _____ Reason for Refusal _____
Medication _____ Reason for Refusal _____

D. _____ I have the following other preferences about psychiatric medications:

5. My preferences about electroconvulsive therapy (ECT or Shock Treatment)

My wishes regarding electroconvulsive therapy are as follows:
Initial A or B.:
A. _____ I do not consent to electroconvulsive therapy.
B. _____ I consent, and authorize my agent to consent, to electroconvulsive therapy for the use in my care.
C. _____ Other instructions and wishes regarding the administration of electroconvulsive therapy:

PART 4: Statement of My Preferences Regarding Notification of Others, Visitors, and Custody of My Child(ren)

1. I ask that the following person is be told of my admission to a psychiatric facility as soon as possible.
Name: _____ Relationship: _____
Address: _____
Telephone Numbers (H) _____(C)_____(W)_____
This person should be permitted to visit me: Yes_____ No _____

In the event that I am unable to care for my child(ren)or pets, I want the following person as my first choice to care for and have temporary custody of my child(ren) or pets:

Name: _____ Relationship: _____
Address: _____
Telephone Numbers (H) _____(C)_____(W)_____

If the person named above is unable to care for and have temporary custody of my child(ren) or pets, I want one of the following people to do so.

My Second Choice
Name: _____ Relationship: _____
Address: _____
Telephone Numbers (H) _____(C)_____(W)_____

PART 5: Statement of My Preferences Regarding Revocation of or Ending This Psychiatric Advance Directive
Initial all paragraphs that you wish to apply to you.

1. Revocation of My Psychiatric Advance Directive during a Period of Incapacity

A. _____ My wish is that this mental health care directive may be ended (revoked, suspended, or terminated) by me only at times that I have the capacity and competence to do so.

B. _____ It is my wish that my agent or other decision maker ask me about my preferences before making a decision regarding mental health care. He or she should take the preferences I express into account when making a decision, even while I am incompetent or incapacitated.

2. Other Instructions about Mental Health Care

Use this space to add any other instructions that you wish to have followed.

If you need to, add pages, numbering them as part of this section. (Label the extra pages **Part 5, Number 2 Other Instructions**)
_____My initials here indicate that additional documents are attached.

3. Duration of Mental Health Care Directive Initial A or B.

A. _____ It is my intention that this advance directive will remain in effect until revoked (canceled) in writing by me.

OR

B. _____ It is my intention that this advance directive will automatically expire two years from the date it was completed.

If my choice above is not valid under state law, then it is my intention that this advance directive remain in effect for as long as the law permits.

If you have attached any additional pages to this form, a date and signature on each of the additional pages I required at the same time you date and sign this psychiatric advance directive.

Part 6: Legal Authority

I have made this document willingly. I am thinking clearly. This document states my wishes about my future health care decisions:

_____ _____

Signature Date

If I cannot sign my name, I ask the following person to sign for me:

_____ _____

Signature (of person asked to sign) Date

_____ _____

Printed Name

Note: This document must be notarized or witnessed. [See individual state requirements on page _____]. Two witnesses OR a Notary Public must verify your signature and the date.

Option 1: Notary Public

State of _____ County of _____

In my presence on _____(date), _____name) acknowledged his or her signature on this document, or acknowledged that he or she authorized the person signing this document to sign on his or her behalf.

_____ Notary Seal _____

Signature of Notary

My commission expires: _____

Option 2: Statement of Witnesses

Witness 1: In my presence on _____(date), _____ name) voluntarily signed this document (or authorized the person signing this document to sign on his or her behalf).

_____ _____
Signature Date

_____ _____
Printed Name Date

Witness 2: In my presence on _____(date), _____ name) voluntarily signed this document (or authorized the person signing this document to sign on his or her behalf).

_____ _____
Signature Date

_____ _____
Printed Name

Requirements for Witnesses by State

Iowa: Notary Public or 2 adult witnesses are required. A witness cannot be: (1) a provider attending the principal on the date this document is signed; (2) an employee of the provider attending the principal on the date this document is signed; (3) the Health Care Agent named in this document; and (4) at least one witness cannot be related to the principal by blood, marriage, or adoption within the third degree of relation.

Minnesota: Notary Public or 2 adult witnesses are required. A witness cannot be the Health Care Agent or alternate Health Care Agent. Of the two witnesses, only one can be a health care provider or an employee of a provider giving direct care on the date the document is signed.

North Dakota: Notary Public or 2 adult witnesses are required. A witness cannot be: (1) the Health Care Agent; (2) the principal's spouse or heir; (3) a person related to the principal by blood, marriage, or adoption; (4) a person entitled to any part of the Estate of the principal upon the death of the principal under a will or deed; (5) any other person who has any claims against the Estate of the principal; (6) a person directly financially responsible for the principal's medical care; or (7) the principal's attending physician. In addition, at least one witness may not be a health care or long term care provider providing direct care to the principal on the date this document is signed or an employee of a health care or long term care provider providing direct care to the principal on the date this document is signed.

South Dakota: Notary Public or 2 adult witnesses are required. A witness cannot be: (1) related to the signer by blood, marriage, or adoption; or (2) be a creditor of the signer nor entitled to any part of the signer's estate under a will now existing or by operation of law.

Acceptance of Appointment of Health Care Agent (Health Care Power of Attorney)
(Required in ND):
I accept this appointment and agree to serve as an agent for health care decisions. I understand I have a duty to act consistently with the desires expressed in this document and to act in good faith. I understand this individual can revoke my designation as an agent at any time in any manner. I will notify this individual if I choose to withdraw from this role while this individual is competent. I will notify this individual's health care provider if I choose to withdraw from this role when this individual is not able to make health care decisions.

_____ _____
Primary Agent Signature Date

_____
Printed Name

_____ _____
Alternate Agent Signature Date

_____
Printed Name

The ACP of _____ (print name) Birth Date _____ Completion Date _____