Psychiatric Advance Directive

Section I: Agent

I, _____, being of sound mind, authorize the following agent to make my mental healthcare decisions in the event that a licensed physician determines that that I lack capacity. Those decisions should be consistent with the instructions I have set out in this psychiatric advance directive. If I have not expressed a choice in this document, my agent has permission to make the decision that he/she determines is in my best interest, taking my personal values, to the extent known by the agent, into consideration.

My agent should be notified immediately of my admission to a psychiatric facility.

Agent's Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Alternate Phone: _____

If the above named person is unavailable, unable, or unwilling to serve as my agent, I designate the following person as my mental healthcare agent.

Alternate Agent's Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Alternate Phone: _____

My agent or alternative agent is my spouse:
____ No - Skip the following question and move on to Section II.
____ Yes - Answer the following questions before moving to Section II.

I _____ (do/do not) desire that he person named as my agent, who is now my spouse, **remain** as my agent **even if** we become legally separated or our marriage is dissolved.

Section II: Guardian

In the event a court determines that a **guardian of the person** should be appointed, I request that the following person be appointed:

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Alternate Phone: _____

In the event a court determines that a **guardian of the estate** should be appointed, I request that the following person be appointed:

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Alternate Phone: _____

The appointment of a guardian or any other decision maker shall not give the guardian or decision maker the power to revoke, suspend, or terminate this directive or the powers of my agent, except as specifically required by law.

In the event that a court determines that a guardian of the person and/or estate should be appointed, it is my desire that the following named individual(s) is/are **not** appointed as my guardian:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Section III: Inpatient Treatment

In the event that I require inpatient psychiatric treatment, I would prefer care at the treatment/alternative care centers listed below:

1st Choice	
2nd Choice	
3rd Choice	
4th Choice	
5th Choice	

For the below listed reasons, I **do not** wish to receive care from the following facilities for psychiatric care:

Facility	Reason

Additional information regarding inpatient care:

_____

_____

_____

_____

_____

_____

Section IV: Emergency Intervention

Nothing in this section constitutes my consent to the use of medication in a <u>non-emergency</u> situation unless expressly stated otherwise.

The following may cause me to experience a mental health crisis:

_____

_____

_____

_____

_____

_____

_____

_____

_____

The following may help me avoid a mental health crisis:

_____

_____

_____

_____

_____

_____

Section IV: Emergency Intervention *(continued)*

Staff at the hospital or crisis center can help me by doing the following:

Staff can minimize use of restraint and seclusion by doing the following:

_____

_____

_____

_____

Section IV: Emergency Intervention *(continued)*

In the event that it is determined that I am engaging in behavior that requires emergency intervention, I **prefer** emergency interventions in the following order:

____ Seclusion

____ Physical Restraint

____ Seclusion and Physical Restraints (combined)

____ Medication in Pill Form

____ Liquid Medication

____ Medication by Injection

____ Other _____

In the event that I am hospitalized, I prefer to be treated by:

Medical Professional	Reason

I prefer **not** to be treated by:

Medical Professional	Reason

Section V: Medication & Treatment Instructions

I agree to the administration of the following medication(s):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

I expressly **do not** consent the administration of the following medication(s):

Medication	Reason

Section VI: Notification

In the event that I am placed in inpatient care, my agent should notify the following individuals immediately:

Name: _____ Relationship: _____

Email: _____ Home Phone: _____

Cell Phone: _____ Work Phone: _____

Name: _____ Relationship: _____

Email: _____ Home Phone: _____

Cell Phone: _____ Work Phone: _____

Name: _____ Relationship: _____

Email: _____ Home Phone: _____

Cell Phone: _____ Work Phone: _____

Section VII: Visitation

In the event that I require inpatient care, I request that the following individuals are given my passcode and placed on my visitation list:

Name: _____ Relationship: _____

Email: _____ Home Phone: _____

Cell Phone: _____ Work Phone: _____

Name: _____ Relationship: _____

Email: _____ Home Phone: _____

Cell Phone: _____ Work Phone: _____

Section VII: Visitation *(continued)*

Name: _____ Relationship: _____

Email: _____ Home Phone: _____

Cell Phone: _____ Work Phone: _____

Name: _____ Relationship: _____

Email: _____ Home Phone: _____

Cell Phone: _____ Work Phone: _____

Name: _____ Relationship: _____

Email: _____ Home Phone: _____

Cell Phone: _____ Work Phone: _____

The following individuals should not be given my passcode and should not be allowed to visit me:

_____ _____

_____ _____

_____ _____

_____ _____

Section VIII: Children

I have a child or children in my care and/or custody:

____ No – Skip the rest of this section and move on to Section IX.

____ Yes – Complete this section before moving on to Section IX.

Section VIII: Children *(continued)*

Initial "Yes" or "No" for each of the following two statements:

Yes	No	
		In the event that I am unable to care for my children, I prefer that the following care for my children
		In the event that a court finds temporary custody is necessary, I prefer the following persons to be considered

First Choice:

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Alternate Phone: _____

Second Choice:

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Alternate Phone: _____

Third Choice:

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Alternate Phone: _____

I request that the following are **not** allowed to care for my children:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Section IX: Additional Instructions

I give the following additional instructions to be followed in the event that I lack capacity:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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_____

_____

_____

_____

_____

_____

Section X: Signature

By signing below, I indicate that I understand the purpose and effect of this document. I understand that this psychiatric advance directive will remain in effect until I revoke it in accordance with Section X of this document.

Signature:_____

Printed Name: _____

Please choose ***one*** of the below options ***before signing***:

Option 1: Notary

State of Arkansas
County of _____

On this the_____ day of _____, 20_____, before me,_____, the undersigned notary, personally appeared _____, known to me or satisfactorily proven to be the person whose name(s) is/are subscribed to the within instrument and acknowledged that he/she/they executed the same for the purposes therein contained. In witness whereof, I have hereunto set my hand and official seal.

_____
Signature of Notary Public

My Commission expires: _____

Option 2: Witnesses

The directive above was signed in our presence by _____ ("principal") to be his/her psychiatric advance directive. At his/her request, we have signed below as witness. We attest that we have complied with A.C.A. § 20-6-103: 1) we are competent adults who are not the named agent; 2) at least one of us is not related to the principal by blood, marriage, or adoption; 3) and we would not be entitled

to any portion of the estate of the principal upon death of the principal under any will or codicil made by the principal existing at the time of execution of the advance directive.

Witness 1

Signature: _____

Printed Name: _____

Date: _____

Address: _____

Witness 2

Signature: _____

Printed Name: _____

Date: _____

Address: _____