New York Health Care Proxy / Advance Directive for Mental Health Treatment of

Name _____ Birthdate ___ /___ /_____

(Please read all the way through this form before starting to fill it in. Attach extra sheets if needed for any items.)

Being of sound mind, and after careful thought, I voluntarily complete and sign this document.

Part A. Health Care Proxy: Appointment of Health Care Agent and Alternate: Authority and Limitations *(Part A is optional. If you are not appointing an agent, skip to Part B.)*

Appointment of Agent and Alternate:

1. I appoint the following person as my health care agent:

Name _____ Relationship _____

Home phone _____-_____-_____ Cell phone _____-_____-_____

Work phone _____-_____-_____ E-mail address _____

(Circle preferred contact method.)

My agent must be promptly notified if I am determined to lack capacity to make my own health care decisions.

2. I appoint the following person as my alternate health care agent, to serve if my agent named above is unable, unwilling or not reasonably available to serve:

Name _____ Relationship _____

Home phone ____ - ____ - _____ Cell phone____-_____-_____

Work phone _____-_____-_____ E-mail address _____

(Circle preferred contact method.)

My alternate agent must be notified immediately if I am determined to lack capacity to make my own health care decisions, and my agent is unavailable, unwilling or unable to act on my behalf.

My Agent's Authority:

My agent's authority to make health care decisions for me will be effective if I lose the capacity to make my own health care decisions.

My agent will have authority to make any and all health care decisions for me in accordance with my instructions provided in Part B, or as otherwise known to him or her, and except as I limit his or her authority below. "Health care decisions" means decisions to consent to, refuse, or withdraw consent to treatment, service or procedure to diagnose or treat my physical or mental condition.

My agent has authority to act for me in treatment and discharge planning.

My agent has full authority to resolve any question regarding my health care wishes, preferences, instructions, directives, or decisions.

Limitations on My Agent's Authority:

My agent cannot admit me to an inpatient mental health facility.

Part B. Instructions to My Agent / Advance Directive to My Health Care Providers *(You can complete as much of Part B as you wish.)*

I voluntarily give these instructions and directives to be followed by my agent, if I have named one, and by my providers, even if I do not have an agent. They will apply if I become unable to make my own health care decisions. They reflect my firm and settled commitment, after careful thought, about my choices for health care. I expect and intend them to be followed to decide the care that I will and will not receive, unless I change or revoke them. I exercise my legal right to refuse treatment to the extent I state below.

General Instructions to My Agent:

When making decisions for me, my agent should follow my instructions in this document. If my instructions in this document do not cover the situation, then my agent should consider what decision I would make, based on other documents I have written, past conversations my agent and I have had, my beliefs and values, and how I have handled other medical and mental health decisions. If what I would decide for myself is still unclear, then my agent should make decisions that s/he believes are in my "best interest," considering the benefits, burdens, and risks of my situation and treatment options.

(Initial and complete 3 if you want your agent to consult with another trusted person, including a mental health care provider)

3. ___ I direct my agent to consult, whenever possible, with the following person before making decisions, but my agent has final authority to decide at all times:

Name _____ Contact information _____.

Instructions to My Agent, if I Have One, and My Health Care Providers:

I request to be treated with empathy and sensitivity.

4. I request my agent, or providers if I have no agent, to notify the following people if I am determined to lack capacity to make my own health care decisions, and also if I am hospitalized:

Name	Relationship	Contact Information
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies:

5. I have allergies to the following medications. The providers listed may be contacted for information. I do not consent to any of these medications.

Medication Provider and contact information

_____ _____

_____ _____

Mental Health Care

(If you want certain priorities or principles to guide your agent or providers, consider checking the choices below, and you can add your own.)

6. For mental health care, my priority is *(initial one or both of the choices below, if you wish.)*

___ relief of symptoms, including recovering enough to leave the hospital; or

___ avoiding side-effects and negative reactions from treatment.

Any other priorities or principles for your agent or providers to follow: _____

_____

_____

Psychiatric Medications:

7. Medications that have worked well for me in the past to reduce symptoms or stabilize me in a crisis: _____

_____

8. Psychiatric medications I WILL ACCEPT, but only under certain conditions (*for example, maximum dose; only if I have certain symptoms; only so long as certain side-effects are avoided; only if recommended by Dr. _____; only if all other reasonable treatments have been tried, but none has worked well enough for me to leave the hospital.)*

Medication	Condition	Reason
_____	_____	_____
	_____	_____
	_____	_____
_____	_____	_____
	_____	_____
	_____	_____
_____	_____	_____
	_____	_____

9. Psychiatric medications I WILL NOT ACCEPT:

Medication	Reasons
_____	_____
	_____
	_____
_____	_____
	_____
	_____
_____	_____
	_____
	_____

10. *Initial which instruction you want to apply for psychiatric medications that you have not already listed in this document:*

a. ___ If my attending psychiatrist recommends a medication not listed above, I am willing to try it.
b. ___ If my attending psychiatrist recommends a medication not listed above, my agent should decide.

c. ___ I will only accept the medications that I have specifically listed above.

<u>Electroconvulsive Therapy (ECT)</u>:

11. *(Read all choices first. Then initial those you want to apply.)*

___ I will accept ECT as recommended by my treating physician.

___ I will accept ECT only as recommended by Dr. _____, contact information _____.

___I will accept ECT only up to ___ treatments *(fill in the number of treatments)*.

___ I will accept ECT only under condition that _____
_____
(list any other conditions or limitations that you want to apply).

___ My agent will decide as generally instructed on Page 3.

___ I will not accept ECT under any circumstances.

Reasons for your choices, if you wish to provide them:
_____
_____
_____

Restraint, Seclusion and Emergency Medication:

12. Behavior Management / Crisis Prevention / Calming Plan: I request that a hospital try the following to calm me in a crisis, before using restraint, seclusion or emergency medication: *(Consider writing what is in your WRAP plan here.)*
_____
_____
_____

The following may trigger a crisis and should be avoided:
_____
_____

I may show the following signs before reaching a crisis: _____
_____

This information in paragraph 12 should be included in my Individual Crisis Prevention Plan/Behavior Management Plan.

13. If one of the following must be used to manage an emergency situation after attempting less restrictive interventions, my order of preference among these is: (*Mark 1, 2 and 3 for your 1st, 2nd and 3rd preferences)*

___ Restraint ___ Seclusion ___ Emergency Medication.

14. Any other instructions or preferences about mental health care *(For example, do you prefer to be alone when not feeling well? Not to be touched?)*

_____
_____
_____
_____

Life-Sustaining Treatment / Living Will:

(You may want to give instructions to your agent or providers on life-sustaining medical care, in case you lose capacity and are gravely ill or injured – such as CPR, respirator, or tube feeding. A sample form for this is at http://endoflifechoicesny.org/wp-content/uploads/2013/08/Choosing-Your-End-of-Life-Health-Care-Treatments.pdf. You can attach the instructions to this form, or complete it later and give it to the same people.)

(Initial 15 *if you want to attach end-of-life instructions.)*

15. ___ I am attaching a form with instructions on life-sustaining medical treatment. It is made part of this document. It applies whether or not I have an agent. If I have no agent, it is my "Living Will."

Part C. Duration, Signature, Witnesses (*Part C is required.)*

16. How Long This Document Will Last *(Initial one):**
___ Unless I revoke or change it, this document shall remain in effect indefinitely.
___ Unless I revoke or change it, this document shall remain in effect until the following date or condition: _____.

** (If your agent is your spouse and you are later divorced or legally separated, s/he is removed as your agent unless you write otherwise in your proxy.)*

Signed **X** _____ Date_____

Witness Signatures:

I declare that the person who signed this document is personally known to me. S/he appears to be of sound mind and acting willingly and free from duress. S/he signed this document in my presence. I am not the person appointed as agent or alternate agent by this document.

Witness 1:

Signature _____ Date _____

Print name _____

Address _____

Witness 2:

Signature _____ Date _____

Print name _____

Address _____

WALLET CARD

Directions: Print this page, fill in your information, then cut around the black line and fold at the dotted line. Carry this card in your wallet. Tape or staple this card to your insurance card.

Proxy/Advance Directive Alert Card

The person carrying this card
Name: _____
has a Health Care Proxy or Advance Directive.
Please see reverse side.

My Proxy or Advance Directive is on file with:

_____

_____

My Health Care Agent is _____

Phone: _____ Email _____