Advance Instruction for Mental Health Treatment

PRINT YOUR NAME

DATE OF BIRTH

FOR INFORMATION CONTACT:
PATIENT RELATIONS AT 910 615-6120

"MY VOICE – *my choice.*"

MY WISH FOR:

- *The kind of mental health treatment I want or do not want.*
- *What I want my loved ones to know.*

CAPE FEAR VALLEY HEALTH

An Advance Directive for Mental Health Treatment

This form allows you to express your wishes for future mental health care treatment and to guide decisions about that care. It does not address financial decisions. Although there is no legal requirement for you to have an advance directive, completing this form may help you to receive the mental health care you desire. If you are 18 years old or older and are able to make and communicate health care decisions, you may use this form.

1. **What is an advance directive for mental health treatment?** This form allows you to give specific instructions for your future mental health treatment. It does not appoint anyone to make those decisions on your behalf. If you would like to appoint someone to make those decisions on your behalf, you may complete a separate Health Care Power of Attorney document.
2. **When will this advance instruction for mental health treatment become effective?** This document will become effective if your doctor determines that you have lost the ability to make your own health care decisions.
3. **How can you revoke this advance instruction for mental health treatment?** If you are competent, you may revoke this advance instruction document in any way that makes clear your desire to revoke it. For example, you may destroy this document, write "void" across this document, tell your doctor that you are revoking the document, or complete a new advance instruction.
4. **What should I do with my advance instruction for mental health treatment?** Once you have signed the document in the presence of a notary, there are a few steps to take to be sure your wishes are carried out by your doctors, family and loved ones.
   - Make copies of the pages with the barcode on them.
   - Mail or give a copy to your doctor and/or therapist. If you mail it, be sure to include a cover letter with your address, date of birth, and phone number.
   - Discuss the Advance Instruction with your doctor(s) and/or therapist(s). If it critical that you communicate with your providers directly what your wishes are. Make sure you are both clear on what you want and that your wishes will be honored by the physician.
   - Give copies of your document(s) to family and loved ones and to your Health Care Agent if you have separately appointed one. You may also want to give a copy to your clergy.
   - Keep the original document(s) in a safe and easily-accessible place at all times. You should make an extra copy for yourself in case you lose your original or it is accidentally destroyed or damaged. Do not put these documents in a safety deposit box.
   - Label one copy "Hospital" and bring it with you if you are admitted to a hospital or other treatment facility. Give it to the hospital staff so they can put it in your chart. If, at a later date, you change your document(s), make sure the hospital receives the updated document(s).
   - Make a list of everyone to whom you gave a copy of your document(s). If, at a later date, you change your document(s), you will have a list of who needs updated document(s).

ADVANCE INSTRUCTION FOR MENTAL HEALTH TREATMENT

My name is _____ My date of birth is:_____

My address is:_____

_____

My phone number is: _____

If a physician or eligible psychologist determines 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, I direct the following:

A. PSYCHOACTIVE MEDICATIONS

If I become incapable of giving or withholding informed consent for mental health treatment, my instructions regarding psychoactive medications are as follows: (**Place initials beside choice**.)

_____ I consent to the administration of the following medications:

_____ I do not consent to the administration of the following medications:

_____

_____

Conditions or limitations:_____

_____

_____

B. ADMISSION TO AND RETENTION IN FACILITY

If I become incapable of giving or withholding informed consent for mental health treatment, my instructions regarding admission to and retention in a health care facility for mental health treatment are as follows: (**Place initials beside choice**.)

_____ I consent to being admitted to a health care facility for mental health treatment.

My facility preference is_____

_____ I do not consent to being admitted to a health care facility for mental health treatment.

This advance instruction cannot, by law, provide consent to retain me in a facility for more than 10 days.

Conditions or limitations_____

_____

C. ADDITIONAL INSTRUCTIONS

These instructions shall apply during the entire length of my incapacity.

In case of mental health crisis, please contact:

1. Name:_____ Relationship to Me:_____

Home Address:_____

Home Telephone Number:_____ Work Telephone Number:_____

2. Name:_____ Relationship to Me:_____

Home Address:_____

Home Telephone Number:_____ Work Telephone Number:_____

3. My Physician:

Name:_____ Telephone Number:_____

4. My Therapist:

Name:_____ Telephone Number:_____

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

_____

_____

The following may help me 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:

_____

_____

I give permission for the following person or people to visit me:

_____

_____

Instructions concerning any other medical interventions, such as electroconvulsive (ECT) treatment (commonly referred to as "shock treatment"):

_____

_____

Other instructions:_____

_____

_____

_____ I have attached an additional sheet of instructions to be followed and considered part of this advance instruction. (**Please initial if providing additional instructions.**)

D. SHARING OF INFORMATION BY PROVIDERS

I understand that the information in this document may be shared by my mental health treatment provider with any other mental health treatment provider who may serve me when necessary to provide treatment in accordance with this advance instruction.

Other instructions about sharing of information:

_____

_____

[THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK]

STOP: DO NOT COMPLETE THIS PAGE WITHOUT A NOTARY PRESENT

By signing here, I indicate that I am mentally alert and competent and not under any duress, fraud, or undue influence, fully informed as to the contents of this document, and understand the full import of this grant of powers to my health care agent. I am aware and understand that this document sets forth my wishes concerning the future conditions under which life-prolonging measures may be withheld or discontinued in accordance with my advance instructions and understand the full impact of having made any advance instruction for my mental health treatment.

Date: _____ Signature: _____

I hereby state that the person named above, _____, signed the document in my presence, and appears to be of sound mind and not under duress, fraud, or undue influence. I am not related to the principal by blood, marriage, or adoption and I would not be entitled to any portion of the estate of the principal under any existing will or codicil of the principal or as an heir under the Intestate Succession Act, if the principal died on this date without a will. I also state that I am not the principal's attending physician, nor a licensed health care provider or mental health treatment provider who is (1) an employee of the principal's attending physician or mental health treatment provider, (2) an owner, operator, or employee of an owner or operator of the health facility in which the principal is a patient, or (3) an employee of a nursing home or any adult care home where the principal resides. I further state that I do not have any claim against the principal or the estate of the principal.

Date: _____ Witness: _____

Date: _____ Witness: _____

_____COUNTY, _____STATE

Sworn to (or affirmed) and subscribed before me this day by

_____ *(type/print name of signer)*

_____ *(type/print name of witness)*

_____ *(type/print name of witness)*

Date: _____ _____

Signature of Notary Public

(Official Seal)

_____, Notary Public

Printed or typed name

My commission expires: _____