## Part I: My Purpose and Intent

My name is ____________________________________.

**Why I Am Making this Document.** I sometimes have periods of mental health crisis, when I am not able to make informed decisions for myself. I create this Mental Health Advance Directive to state my choices now, when I have full decision making capability, about what my mental health care should be during those times when I cannot make informed decisions for myself.

I understand that if I am in a period of mental health crisis, a guardian or other decision maker might be appointed by a court to make mental health decisions for me. If that happens, I specifically direct that the appointed guardian or decision maker follow the instructions in my Mental Health Advance Directive. I specifically intend that this document will take priority over all other means of understanding the intentions and wishes I would express during periods when I am NOT in mental health crisis.

**Possible Invalid Portions.** Even if a portion of this Mental Health Advance Directive is found to be not valid under West Virginia state law, I want this document to be considered a statement of my wishes as expressed when I was not in a mental health crisis. I want this Mental Health Advance Directive to be accorded the greatest possible legal weight and respect.

**When My Mental Health Advance Directive Will Be In Effect.** My Mental Health Advance Directive will have no legal effect until the time that I cannot make my own informed decisions about my mental health care for myself. At that point my Mental Health Advance Directive will come into effect. When I regain the ability, referred to as "capacity", to make informed decisions for myself, then my wishes at that time will override any different provision in this Mental Health Advance Directive. My "incapacity" is to be determined by a qualified physician and a second qualified physician or qualified psychologist.

**Effect of Change of Representative.** If I have named a "representative" to make health care decisions for me when I do not have the ability to make informed decisions for myself, then my wishes expressed in this Mental Health Advance Directive should be honored whether or not my representative dies or withdraws or if I have no representative appointed at the time of the execution of this document. If I have not named a representative, these instructions shall be binding upon whomever may be appointed as my representative or other decision maker.

**Priority Over Other Documents.** I intend my Mental Health Advance Directive to take priority over any and all medical power of attorney and/or other advance directives I have previously executed, to the extent that they are inconsistent with this document.

**My Wish To Be Involved If Possible.** Regardless of my decision making ability and this mental health advance directive, I want to be fully informed about and allowed to participate to the greatest extent possible in any mental health care decision for me.

## Part II: Appointment and Authority of a Representative

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**Option 1:** I do **NOT** want to appoint a representative to make health care decisions for me.

Sign here: ______________________ Date here: _______________

OR

**Option 2:** I **DO** want to appoint a representative to make health care decisions for me, following the instructions in this Mental Health Advance Directive, if I am unable to make informed decisions for myself. [Note: Your mental health treatment provider cannot be named as your Representative.]

| Preferred Person To Be My Representative: | |
|---|---|
| Name | |
| Street Address | |
| City, State, Zip | |
| Day Phone | |
| Evening Phone | |

| Backup Person To Be My Representative, if my preferred person is unwilling, unable, or not reasonably available to make mental health decisions for me (this is optional): | |
|---|---|
| Name | |
| Street Address | |
| City, State, Zip | |
| Day Phone | |
| Evening Phone | |

| **Powers of My Representative, or Limitations Upon My Representative** | |
|---|---|
| My representative has full power and authority to make mental health care decisions for me based on this mental health advance directive and on my wishes as otherwise known to my representative. This authority includes, but is not limited to, the following: | |
| Requesting, receiving, and reviewing any information, oral or written, regarding my mental health, including, but not limited to, medical and hospital records, and consent to disclosure of this information | **Describe any limitation on this power:** |
| Making all necessary arrangements for mental health care services on my behalf, including the authority to select, employ, and discharge mental health care providers: | **Describe any limitation on this power:** |

| Authorizing my admission to or discharge from (including transfer to another facility), even against medical advice, any mental health care facility or service | **Describe any limitation on this power:** |
|---|---|
| Signing any documents providing consent for treatment, withdrawal of treatment or refusal to permit treatment, and any necessary waivers or releases from liability associated with refusal to permit treatment or withdrawal of treatment as required by a hospital, physician, or other health care provider; | **Describe any limitation on this power:** |
| Admitting me as a voluntary patient to a psychiatric facility and consenting to any psychiatric treatment consistent with my desires as outlined in this document. | **Describe any limitation on this power:** |
| Any Other Powers Reasonably Necessary | **Describe any limitation on other powers:** |

## Part III: My Instructions Regarding My Mental Health Care

**Crisis Response**

The following signs and symptoms may indicate that I am in a mental health crisis: -

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

____________________________________________________________________________

**Helpful Interventions or Treatments.** I request the following interventions/activities in a mental health crisis regardless of the setting (community, outpatient, or inpatient), which may reduce my symptoms, make me more comfortable, and keep me safe:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**Unhelpful Interventions or Treatments.** In a psychiatric emergency, PLEASE AVOID the following interventions that make me feel worse:

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

## Treatment Programs/Facilities

**Alternative to Psychiatric Hospitalization.** If 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 would prefer to receive care in programs/facilities designed as alternatives to psychiatric hospitalization.

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

**Preferred Hospital(s) If Necessary.** If I am to be admitted to a hospital for 24-hour care, I would prefer to receive care at the following hospitals from the following physicians:

Facility Attending Physician

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

**Hospitals or Programs Not To Be Used.** I do ***not*** wish to be admitted/committed to the following hospitals or programs/facilities for psychiatric care for the reasons I have listed:

| Facility Name | Reason(s) Why I Don't Want This Facility |
|---|---|
| | |
| | |
| | |
| | |

**Medications**

I **consent** or **do not consent** to the administration of the following medications:

| Medication | **Yes, I CONSENT To This Medication** | **No, I DO NOT CONSENT to This Medication** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

I have allergic and/or adverse reactions to the following medications:

| |
|---|
| |
| |
| |
| |
| |

I have the following additional preferences about psychiatric medications:

| |
|---|
| |

**Other Therapies**

| | **I DO NOT CONSENT** | **I CONSENT IN FULL** | I CONSENT, **WITH THE FOLLOWING LIMITATIONS OR CONDITIONS** |
|---|---|---|---|
| Electroconvulsive Therapy (ECT or "Shock Treatment" | | | |
| Experimental Studies or Drug Trials | | | |

**Other Instructions About My Mental Health Care**

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

## Notifying Other People of My Treatment, and Instructions About Visits

I desire that the following people be notified immediately that I have been admitted to a facility:

| Name | |
|---|---|
| Street Address | |
| City, State, Zip | |
| Day Phone | |
| Evening Phone | |
| May Visit me? | (Check One): _____ May Visit Me _____ May Not Visit Me |

| Name | |
|---|---|
| Street Address | |
| City, State, Zip | |
| Day Phone | |
| Evening Phone | |
| May Visit me? | (Check One): _____ May Visit Me _____ May Not Visit Me |

| Name | |
|---|---|
| Street Address | |
| City, State, Zip | |
| Day Phone | |
| Evening Phone | |
| May Visit me? | (Check One): _____ May Visit Me _____ May Not Visit Me |

| Name | |
|---|---|
| Street Address | |
| City, State, Zip | |
| Day Phone | |
| Evening Phone | |
| May Visit me? | (Check One): _____ May Visit Me _____ May Not Visit Me |

I ***do not* consent to visitation** by the following people while I am at a facility:

| Name | |
|---|---|
| City, State | |

| Name | |
|---|---|
| City, State | |

| Name | |
|---|---|
| City, State | |

**Temporary Custody Of Dependents**

I have the following dependent(s) (e.g., children, emotional support service animal, pets, etc.):
___________________________________________________________________________________

___________________________________________________________________________________

In the event that I am unable to care for my dependent(s), I desire that the following person have temporary custody of the identified dependent(s):

| Name | |
|---|---|
| Street Address | |
| City, State, Zip | |
| Day Phone | |
| Evening Phone | |

| Name | |
|---|---|
| Street Address | |
| City, State, Zip | |
| Day Phone | |
| Evening Phone | |

**When I May Revoke This Mental Health Advance Directive**

Choose One:

| __________ (Initial) | My wish is that, in accordance with state law, this Mental Health Advance Directive may be revoked by me at any time. |
|---|---|

OR

| ___________ (initial) | My wish is that I may revoke (change my mind) this Mental Health Advance Directive **ONLY** at times that I have the ability to make my own mental health care decisions. I understand that by choosing this option I am giving up the right to change my mind at any time about anything I have written in this advance directive. I give up this right in order to assure that my thoughts expressed in this document will be in effect during the times that I am not able to make my own informed decisions. |
|---|---|

## Part V: Signature Page

I, ______________________________________________________________________ (*insert your printed name and address*) certify that I understand the purpose and effect of this Mental Health Advance Directive. The instructions and wishes stated in this document are my choices about how mental health treatment decisions will be made for me when I am not able to make my own informed decisions about mental health treatment.

__________________________________________ ______________________________

(*Your Signature*) (*Date Signed*)

**Statements By Witnesses**

The directive above was signed in my presence and declared by ___________________________, who is called the "Principal," to be his/her Mental Health Advance Directive. At his/her request, I sign my name below as witness.

I did not sign the Principal's signature above. I am at least eighteen years of age and am not related to the Principal by blood or marriage. To the best of my knowledge I am not entitled to inherit or receive any portion of the estate of the Principal, or to receive any share or distribution under any will of the Principal or codicil thereto. To the best of my knowledge I am not legally responsible for the costs of the Principal's medical or other care. I am not the Principal's attending physician. I am not the representative or alternate representative of the Principal.

| Witness 1 | |
|---|---|
| Name | |
| Street Address | |
| City, State, Zip | |
| Date Signed | |
| Signature | |

| Witness 1 | |
|---|---|
| Name | |
| Street Address | |
| City, State, Zip | |
| Date Signed | |
| Signature | |

*(for use by the notary)*

STATE OF ______________________________, County of ________________________________

Subscribed and sworn to or affirmed before me by the Principal, ________________________________,

And (names of witnesses) ________________________________________ and

_____________________________________, witnesses, as the voluntary act and deed of the

Principal, this ______________ day of ___________, 20____.

_____________________________________

(Signature of Notary)

My commission expires:_________________________

## Record of Mental Health Advance Directive

- *Complete the lines below and attach to your mental health advance directive.*
- *Make copies of your completed and signed mental health advance directive.*
- *Give copies to those whom you want to be aware of your choices, (e.g., representative(s), case manager/social worker, doctor(s), psychologist/therapist, advocate/attorney, family/friends, or facilities)*

**My Name:** ____________________________________________

**My *Representative's* Contact Information:**

**Name:** ____________________________________________
**Address:** ____________________________________________
**Phone Numbers:** ____________________________________________

**I have given copies of this form to:**

**Name/Location:** ____________________________________________
**Address:** ____________________________________________
**Phone Numbers:** ____________________________________________

**Name/Location:** ____________________________________________
**Address:** ____________________________________________
**Phone Numbers:** ____________________________________________

**Name/Location:** ____________________________________________
**Address:** ____________________________________________
**Phone Numbers:** ____________________________________________

**Name/Location:** ____________________________________________
**Address:** ____________________________________________
**Phone Numbers:** ____________________________________________

**Name/Location:** ____________________________________________
**Address:** ____________________________________________
**Phone Numbers:** ____________________________________________

**Name/Location:** ____________________________________________
**Address:** ____________________________________________
**Phone Numbers:** ____________________________________________

## Notification of Mental Health Advance Directive

*Complete the lines that apply.*

- ***Initial*** *the blank to the left of the statement that applies.*
- *Carry with you.*

**MENTAL HEALTH CARE PROFESSIONALS AND OTHERS PLEASE NOTE:**

**My name: ____________________________________________________________**

**I have a mental health advance directive, a document stating my preferences as to mental health care and involuntary psychiatric hospitalization and treatment. If I am deemed incapacitated, please obtain and honor this document. Copies may be found at:**

**Name/Location: _________________________________Phone: _______________**
**Name/Location: _________________________________Phone: _______________**
**Name/Location: _________________________________Phone: _______________**
**Name/Location: _________________________________Phone: _______________**
**Name/Location: _________________________________Phone: _______________**
**Name/Location: _________________________________Phone: _______________**

**___ I have not appointed a representative for mental health care decision-making.**

**OR**

**___ I have appointed a representative for mental health care decision-making.**
**Please contact this person immediately:**

**Name: __________________________________________________**

**Address: _____________________________________________________**

**Phone Numbers: _____________________________________________________**