By: _____ Date of Birth: _____

(Print Name) (Month/Day/Year)

1. STATEMENT OF INTENT

I, _____, being of sound mind, willfully and voluntarily make this psychiatric advance directive as a means of expressing in advance my informed choices and consent regarding my mental health care in the event I become incapable of making informed decisions on my own behalf. I understand this document becomes effective if it is determined by a physician or licensed psychologist who has personally examined me, or in the opinion of a court, that I lack the capacity to understand the risks, benefits, and alternatives to a mental health care treatment decision under consideration and I am unable to give or communicate rational reasons for my mental health care treatment decisions because of impaired thinking, impaired ability to receive and evaluate information, or other cognitive disability.

If I am deemed incapable of making mental health care decision, I intend for this document to constitute my advance authorization and consent, based on my past experiences with my illness and knowledge gained from those experiences, for treatment that is medically indicated and consistent with the preferences I have expressed in this document.

I understand the document continues in operation only during my incapacity to make mental health care decisions. I understand I may revoke this document only during periods when I am mentally capable.

I intend for this psychiatric advance directive to take precedence over any advance director for health care, durable power of attorney for health care, health care proxy or living will that I have executed prior to executing this form to the extent that such other documents relate to mental health care and are inconsistent with this executed document.

In the event that a decision maker is appointed by the court to make mental health care decisions for me, I intend this document to take precedence over all other means of determining my intent while I was competent.

It is my intent that a person or facility involved in my care shall not be civilly liable or criminally prosecuted for honoring my wishes as expressed in this document or for following the directions of my agent.

2. INFORMATION REGARDING MY SYMPTOMS

The following are symptoms or behaviors I typically exhibit when escalating toward a mental health crisis. If I exhibit any of these symptoms or behaviors, an evaluation may be needed regarding whether I am capable of making mental health care decisions (Limit 500 characters/no spaces):

The following may cause me to experience a mental health crisis or to make my symptoms worse (Limit 500 characters/no spaces):

The following techniques may be helpful in de-escalating my crisis (Limit 500 characters/no spaces):

When I exhibit the following signs, I would like to be evaluated to determine whether I have regained the capacity to make my mental health care decisions:

3. PREFERRED CLINICIANS

The names of my doctors, therapists, pharmacists, and other mental health care professionals and their telephone numbers are:

A.

B

C

D

E.

I prefer and consent to treatment from the following clinicians:

Names:

A

B

C

D

E.

I refuse to be treated by the following clinicians:

4. TREATMENT INSTRUCTIONS

Medications

I am currently using and consent to continue to use the following medications (include all medications, whether for mental health care or general health care treatment).

If additional medications become necessary, I prefer and consent to take the following medications:

I cannot tolerate the following medications because:

I am allergic to the following medications:

If my preferred medications cannot be given and I have not appointed an agent in PART TWO to make alternative decisions for me, I want my treating physician to choose an alternative medication that would best meet my mental health needs, subject to any limitations I have expressed in my treating instructions above. (Check "yes" if you agree with this statement or "no" if you disagree with this statement.)

_____Yes
_____No

In the event I need to have medications administered, I would prefer and consent to the following methods (Check "yes" or "no" and list a reason for your request if you have one.):

Medication in pill form:

_____Yes
_____No

Reason for no medication in pill form:

Liquid medication:

_____Yes
_____No

Reason for no medication in liquid form:

Medication by injection:

_____Yes
_____No

Reason for no medication by injection

Covert medication (without my knowledge in drink or food):

_____Yes
_____No

Reason for no hidden medication:

Hospitalization
Hospitalization is not my first choice. It is my intention, if possible, to stay at home or in the community with the following supports:

If I need outpatient therapy, I prefer and consent to it being provided by:

Additional instructions that may help me avoid a hospitalization:

Treatment Facilities
If it becomes necessary for me to be hospitalized, I would prefer and consent to being treated at the following facilities:

I refuse to be treated at the following facilities:

Reason (s) for wishing to avoid the above facilities:

I generally react to being hospitalized as follows:

Staff at a facility can help me by doing the following:

I give permission for the following people to visit me:

1. Visitor name, relationship, and contact information

2. Visitor name, relationship, and contact information

3. Visitor name, relationship, and contact information

4. Visitor name, relationship, and contact information

5. Visitor name, relationship, and contact information

Additional Interventions
I prefer the following interventions as indicated by my initials, and I consent to any intervention where I have initialed next to "yes." *(Please place your initials in the blanks.)*

Seclusion:
____Yes
____No

Reason:

Physical Restraint:
____Yes
____No

Reason:

Experimental treatment:
____Yes
____No

Reason:

Electroconvulsive therapy (ECT):
____Yes
____No

Reason:

Any limitations on consent to the administration of electroconvulsive therapy:

Other instructions as to my preferred interventions:

5. ADDITIONAL STATEMENTS
This section is optional. PART ONE will be effective even if this section is left blank. This section allows you to state additional mental health treatment preferences, to provide additional guidance to your mental health care agent (if selected in PART TWO), or to provide information about your personal or religious values about your mental health care and treatment. Understanding that you cannot foresee everything that could happen to you, you may want to provide guidance to your mental health care agent about following your mental health treatment preferences.

PART TWO: MENTAL HEALTH CARE AGENT

PART ONE will be effective even if PART TWO is not completed. If you do not wish to appoint an agent, do not complete PART TWO. A provider who is directly involved in your health care or any employee of that provider may not serve as your mental health care agent unless the employee is your family member, friend or associate and is not directly involved in your health care. An employee of the Department of Behavioral Health and Developmental Disabilities or a local public mental health agency or of any organization that contracts with a local public mental health authority may not serve as your mental health care agent unless the person is your family member, friend or associate and is not directly involved in your health care. If you are married, a future divorce or annulment of your marriage will revoke the selection of your current spouse as your mental health care agent unless you indicate otherwise. If you are not married, a future marriage will revoke the selection of your mental health care agent unless the person you selected as your mental health care agent is your new spouse.

6. MENTAL HEALTH CARE AGENT

I select the following person as my mental health care agent to make mental health care decisions for me:

Name:
Address:
Home Phone:
Work Phone:
Mobile Phone:

Agent's acceptance: I have read this form, and I certify that I do not, have not, and will not provide mental health care and treatment for: Full Name:

I accept the designation as agent for: Full Name:

Agent's signature/date: _____

7. BACK-UP MENTAL HEALTH CARE AGENT

PART TWO will be effective even if this section is left blank.

If my mental health care agent cannot be contacted in a reasonable time period and cannot be located with reasonable efforts or for any reason my mental health care agent is unavailable or unable or unwilling to act as my mental health care agent, then I select the following, each to act successively in the order named, as my back-up mental health care agent (s):

Name:
Address:
Home Phone:
Work Phone:
Mobile Phone:

Back-up Agent's acceptance: I have read this form, and I certify that I do not, have not, and will not provide mental health care and treatment for: Full Name:

I accept the designation as agent for: Full Name:

Back-up Agent's signature/date: _____

8. GENERAL POWER

My mental health care agent will make mental health care decisions for me when I have been determined in the opinion of a physician or licensed psychologist who have personally examined me, or in the opinion of the court, to lack the capacity to understand the risks and benefits of, and the alternatives to, mental health care treatment decisions under consideration and I am unable to give or communicate rational reasons for my mental health care decisions because of impaired thinking, impaired ability to receive and evaluate information, or other cognitive disability.

My mental health care agent will have the same authority to make any mental health care decision that I could make. My mental health care agent's authority includes, for example, the power to:

- Request and consent to admission or discharge from any facility;
- Request, consent to, authorize, or withdraw consent to any type of provider or mental health care that is consistent with my instructions in PART ONE of this form and subject to the limitations set forth in Section 4 of PART ONE; and
- Contract for any health care facility or service for me, and to obligate me to pay for these services (and my mental health care agent will not be financially liable for any services or care contracted for me or on my behalf).

My mental health care agent will be my personal representative for all purposes of federal or state law related to privacy of medical records (including the Health Insurance Portability and Accountability Act of 1996; HIPAA) and will have the same access to my medical records that I have and can disclose the contents of my medical records to others for my ongoing mental health care.

My mental health care agent may accompany me in an ambulance or air ambulance if in the opinion of the ambulance personnel protocol permits a passenger, and my mental health care agent may visit or consult with me in person while I am in a facility if its protocol permits visitation.

My mental health care agent may present a copy of this psychiatric advance directive in lieu of the original, and the copy will have the same meaning and effect as the original.

I understand that under Georgia law:

- My mental health care agent may refuse to act as my mental health care agent; and
- A court can take away the powers of my mental health care agent if it finds that my mental health care agent is not acting in accordance with this directive.

9. GUIDANCE FOR THE MENTAL HEALTH CARE AGENT
In the event my directive is being used, my agent should first look at my instructions as expressed in PART ONE. If a situation occurs for which I have not expressed a preference, or in the event my preference is not available, my mental health care agent should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in PART ONE, my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my mental health care agent should make decisions for me that my mental health care agent believe are in my best interests, considering the benefits, burdens, and risks of my current circumstances and treatment options.

I impose the following limitations on my agent's authority to act on my behalf:

10. WHEN SPOUSE IS MENTAL HEALTH CARE AGENT (initial if you agree with the following statement; leave blank if you do not agree)

_____I desire the person I have named as my agent, who is now my spouse, to remain my agent even if we become divorced or our marriage is annulled.

PART THREE: OTHER RELATED ISSUES

PART THREE is optional. This psychiatric advance directive will be effective even if PART THREE is left blank.

11. GUIDANCE FOR LAW ENFORCEMENT

I typically react to law enforcement in the following ways:

The following person (s) may be helpful in the event of law enforcement involvement:

Name:
Relationship:
Home Phone:
Work Phone:
Mobile Phone:

Name:
Relationship:
Home Phone:
Work Phone:
Mobile Phone:

12. HELP FROM OTHERS

The following people are part of my support system and should be contacted in the event of a crisis:

1. Supporter name, relationship, contact information, and responsibility
2. Supporter name, relationship, contact information, and responsibility
3. Supporter name, relationship, contact information, and responsibility

PART FOUR: EFFECTIVENESS AND SIGNATURES

This psychiatric advance directive will become effective only if I have been determined in the opinion of a physician or licensed psychologist who has personally examined me, or in the opinion of a court, to lack the capacity to understand the risks and benefits of, and the alternatives to, a mental health care decision under consideration and I am unable to give or communicate rational reasons for my mental health care decisions because of impaired thinking, impaired ability to receive and evaluate information or other cognitive disability.

This form revokes any psychiatric advance directive I have executed before this date. To the extent this form is in conflict or is inconsistent with any advance directive for health care, durable power of attorney for health care, health care proxy, or living will executed by me at any time, this form shall control with respect to my mental health care.

Unless I have initialed below and have provided alternative future dates or events, this psychiatric advance directive will become effective at the time I sign it and will remain effective until my death.

_____This psychiatric advance directive will become effective on or upon (date)_____.

(Initials)

_____This psychiatric advance directive will terminate on or upon (date)_____.

(Initials)

You must sign and date or acknowledge signing and dating this form in the presence of two witnesses. Both must be of sound mind and must be at least 18 years of age, but the witnesses do not have to be together or present with you when you sign this form.

A witness:

- *Cannot be a person who was selected to be your mental health care agent or back-up mental health care agent in PART TWO;*
- *Cannot be a provider who is providing mental health care to you at the time you execute this directive or an employee of the provider unless the witness is your family member, friend, or associate and is not directly involved in your mental health care; and*
- *Cannot be an employee of the Department of Behavioral Health and Developmental Disabilities or of a local public mental health agency or of any organization that contracts with a local public mental health authority unless the witness is your family member, friend, or associate and is not directly involved in your mental health care.*

Signatures

By signing below, I state that I am of sound mind and capable of making this psychiatric advance directive and that I understand its purpose and effect.

_____ _____

Signature of Declarant Date

The declarant signed this form in my presence or acknowledged signing this form to me. Based upon my personal observation, the declarant appeared to be of sound mind and mentally capable of making this psychiatric advance directive and signed this form willingly and voluntarily.

_____ _____

Signature of First Witness Date

Print Name: _____

Address: _____

_____ _____

Signature of Second Witness Date

Print Name: _____

Address: _____

This form does not need to be notarized.