INSTRUCTIONS FOR COMPLETING THE GEORGIA PSYCHIATRIC ADVANCE DIRECTIVE

Please use the following instructions to complete the provided form to the best of your ability. All answers should be accurate and detailed. This information will be used by mental health care providers and your mental health care agent (if applicable) to identify an ongoing mental health crisis and to provide treatment during the crisis according to your wishes.

Instructions for PART ONE: PREFERENCES

PART ONE is required. This section *allows you to explain how you would like to receive treatment if you are experiencing a mental health crisis and are unable at that time to make informed decisions about your mental health care. All sections of PART ONE should be completed and should include information from prior mental health crises you may have experienced.*

Header

- Fill in your full name (First, Middle, Last) and date of birth (Month/Day/Year).

1. Statement of Intent
   This section states that, at the time you are completing this form, you are doing so of your own free will and that you understand the purpose of the form and how it will be used.

   - If you agree with the statements in this section, fill in your full name (First, Middle, Last) on the line provided.

2. Information Regarding My Symptoms
   This section allows you to explain past mental health crises you have experienced and what things have made your symptoms better or worse.

   - **First Box**: Explain the signs that usually indicate when you are beginning to experience a mental health crisis. This information will help mental health care providers understand when you may need a mental health care evaluation.

   - **Second Box**: Explain any factors that may lead you to experience a mental health crisis or that may make your symptoms worse.

   - **Third Box**: Explain any techniques or factors that may help you feel better during a mental health crisis or that may help the experience to stop.

   - **Fourth Box**: Explain what behavior mental health care professionals should look for that signifies your mental health crisis is ending and when you would like to receive another evaluation to determine if you can make informed decisions at that time. (If

you are experiencing a mental health crisis and cannot make informed decisions about your mental health care, it is important for health care providers to know what to look for to know when the crisis is ending or when you can make informed decisions again.)

3. Preferred Clinicians
   This section is where you can list the contact information of any health care professionals currently providing you mental health care. You can also list the health care professionals that you agree may provide care for you in the event of a mental health crisis and health care professionals that you do not want to provide care for you.

   - **First Box (A through E)**: List the names and telephone numbers of any doctors, therapists, pharmacists, or any other mental health care professionals you are currently receiving treatment from or have received treatment from in the past.

   - **Second Box (A through E)**: List the names of the health care professionals that you will allow to provide treatment to you in the event of a mental health crisis.

   - **Third Box**: List the names of the health care professionals that you will not allow to provide treatment to you in the event of a mental health crisis.

4. Treatment Instructions

   Medications

   - **First Box:** List **all** medications that you are currently using and that you would like to continue using in the event of a mental health crisis.

   - **Second Box:** List any medications that you prefer to use and that you would like to use in the event of a mental health crisis.

   - **Third Box:** List any medications that you prefer not to use and the reason why you cannot use them.

   - **Fourth Box:** List any medications that you are allergic to.

   - **Preferred Medications**: *This section allows you to provide information about what other treatment options you agree may be used if your preferred methods are unavailable for any reason.*

     - If you agree that your treating physician may choose and administer a different medication to you in the event your preferred medications are unavailable and you have not appointed a mental health care agent or your mental health care

agent is unable to make this decision for you, select “YES”.

- If you do not agree that your treating physician may choose and administer a different medication to you in the event your preferred medications are unavailable and you have not appointed a mental health care agent or your mental health care agent is unable to make this decision for you, select “NO”.

- There are several different techniques listed that may be used to administer medicine to you. For each technique, if you agree that it may be used in the event you need to receive medicine, initial next to “YES” in the space provided. If you do not agree that the technique may be used, initial next to “NO” in the space provided. If you select “NO”, please explain why you do not consent to receiving medication using that technique.

Hospitalization

This form assumes that hospitalization is not your first choice. You would prefer to stay at home, if possible, rather than be admitted to a hospital or mental health facility in the event of a mental health crisis.

- **First Box:** List any supports you would prefer to receive to help you stay at home while experiencing a mental health crisis.

- **Second Box:** Outpatient therapy is treatment that you receive without being admitted to a hospital. If a treating physician determines that you would benefit from outpatient therapy, list a health care provider that you agree may provide this care to you.

- **Third Box:** Provide any additional information or instructions that may be helpful in avoiding hospitalization.

Treatment Facilities

This section allows you to state which facilities you prefer to be treated at if hospitalization becomes necessary, which facilities you do not consent to being treated at and the reasons why, your general reactions to being admitted to a facility, and ways that facility staff can help you while staying in the facility. You can also list any people that you give permission to visit you while you are staying in the facility. Please list the visitor’s full name, relationship to you, and their contact information.

Additional Interventions

This section allows you to state any additional treatment techniques that may be used in the event you experience a mental health crisis. For each technique, if you agree that the

technique may be used, initial in the space next to "YES". If you do not agree that the technique may be used, initial in the space next to "NO". Please explain the reason for each answer.

5. Additional Statements

   This section does not have to be completed, but you may do so if you prefer. This section allows you to provide additional instructions to treating physicians or your mental health care agent (if applicable) about how you want to receive mental health care in the event of a mental health emergency. This information could relate to your personal or religious beliefs and how those impact your preferences for receiving treatment. This information will be useful to your treating physician or mental health care agent in deciding the best treatment options based on your personal wishes.

   - If you wish to provide additional information about your wishes for receiving mental health care treatment, list that information in the box provided. If you do not wish to provide additional information, leave the box blank.

Instructions for PART TWO: MENTAL HEALTH CARE AGENT

Part Two is optional. It allows you to select a mental health care agent who will make mental health care decisions on your behalf if you are unable to do so. This section does not have to be completed, but you may do so if you prefer. If you do not want to appoint an agent, do not complete this section. A provider who is involved with your mental health care or an employee of the provider cannot serve as your mental health care agent unless they are a family member, friend, or associate not directly involved with your health care. An employee of a local mental health agency also cannot serve as your mental health care agent unless they are a family member, friend, or associate not directly involved with your health care.

6. Mental Health Care Agent

   - If you wish to select a mental health care agent, provide their contact information, including their name, address, home phone, work phone, and mobile phone in the boxes provided.

   - You should talk with your mental health care agent about your preference for them to make health care decisions for you in the event you are unable to do so. If your agent agrees to serve in this role, the agent will write their full name, your full name, and sign and date in the boxes provided.

7. Back-Up Mental Health Care Agent

   - If you wish to select another mental health care agent to make health care decisions on your behalf if you are unable to do so, and your first designated agent is also unable to do so, please provide their contact information, including their name,

address, home phone, work phone, and mobile phone in the boxes provided.

- You should talk with your back-up mental health care agent about your preference for them to make health care decisions for you in the event you are unable to do so. If your back-up agent agrees to serve in this role, the agent will write their full name, your full name, and sign and date in the boxes provided.

8. General Power
   This section explains the actions that your mental health care agent may take on your behalf in the event you are unable to make mental health care decisions on your own. If you select a mental health care agent or back-up mental health care agent, please read this section in full with those agents.

9. Guidance For Mental Health Care Agent

   - If there are any actions that you do not want your mental health care agent to take on your behalf, explain those in the box provided. Your agent will use these instructions to decide the best treatment options that align most closely with your wishes.

10. When Spouse Is Mental Health Care Agent
    If you are married and select your spouse to act as your mental health care agent, they will automatically be removed from that role if you ever divorce. However, this section allows you to indicate whether you would still want your spouse to remain your mental health care agent even if you do divorce.

    - If you want your spouse to remain your mental health care agent if you divorce, initial in the space provided.

    - If you do not want your spouse to remain your mental health care agent if you divorce, leave this section blank.

Instructions for PART THREE: OTHER RELATED ISSUES

Part Three is optional and allows you to provide additional information that may be useful in the event of a mental health emergency. This section does not have to be completed, but you may do so if you prefer.

11. Guidance for Law Enforcement

    - **First Box:** List your general reaction to law enforcement, including any past experiences you have had interacting with law enforcement during a mental health crisis.

- If there are any people who may be useful to contact in the event law enforcement becomes involved during a mental health crisis, list their contact information, including their name, relationship, home phone, work phone, and mobile phone in the boxes provided.

12. Help From Others

- If there are any people who provide support to you and who should be notified if you are experiencing a mental health crisis, please list those people in the boxes provided, including their name, relationship, contact information, and responsibility. For example, these people could be your friends, family, neighbors, or treating physicians.

Instructions for PART FOUR: EFFECTIVENESS AND SIGNATURES

Part Four is required. You and your witnesses sign the form here to make it effective. This section must be completed for the form to be valid. If you do not sign or do not have two proper witnesses sign, the form will not be binding on any treating physicians or mental health care agents.

- **First Box:** You may choose whether you want the form the take effect upon a specific date. If you do not want to pick a specific date, the form will take effect immediately after you and your witnesses sign. If you want to pick a specific date for the form to take effect, list that date in the box provided. If you do not want to pick a date and want the form to take effect immediately, leave this box blank.

- **Second Box:** You may also choose whether you want the form to end upon a specific date. If you do not want to pick a specific date, the form will remain in effect until you otherwise terminate it. If you want to pick a specific date for the form to terminate, list that date in the box provided. If you do not want to pick a date and want the form to remain effective, leave this box blank.

- **Third Box:** If you agree that you are of sound mind at the time of creating this form and that you understand the purpose of the document, sign in the box provided and then provide the date.

Your two witnesses must then complete the final sections of the form by signing and providing their name and address. The witnesses must be of sound mind and at least 18 years of age. The witnesses cannot be a person who was selected as your mental health care agent or back-up mental health care agent in Part Two. The witnesses also cannot be a provider who is involved with your health care or an employee of the provider unless they are a family member, friend, or associate not directly involved with your health care. The witnesses also cannot be an employee of a local mental health agency unless they are a family member, friend, or associate not directly involved with your health care.

After you sign the form and two witnesses sign the form, the form is valid. Keep the original signed document in a safe, easily accessible place in your home. Provide copies to your friends, family, and mental health care agents (if applicable).