ADVANCE DIRECTIVE FOR MENTAL HEALTH TREATMENT

FORMS PACKET

1. **Notice and Advance Directive Form**
2. **Mental Status Examination Form**
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4. **Notice to Provider**
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Prepared by the Office of Mental Health and the Mental Health Advocacy Service

If you are thinking about executing an advance directive for mental health treatment, read this first:

This document allows you to make decisions in advance about mental health treatment, which includes but is not limited to psychoactive medication, short-term (not to exceed 15 days) admission to a treatment facility, electroshock therapy and outpatient services. The instructions that you include in this directive will be followed only if two physicians believe that you are "incapable", which means that, due to any infirmity, you are currently unable to make or to communicate reasoned decisions regarding your mental health treatment.

Your instructions cannot limit the state's authority to take you into protective custody, or to involuntarily admit or commit you to a treatment facility. Your instructions can be disregarded in an emergency if your instructions have not reduced the behavior that has caused the emergency. In a non-emergency, you may be medicated contrary to your wishes only after an administrative review in which you are provided legal counsel.

You may also appoint a person as your representative to make treatment decisions for you if you become incapable. The person you appoint must act consistently with your wishes as expressed in this document or, if not stated, as otherwise known by your representative. If your representative does not know your wishes, he or she must make decisions in your best interest. For the appointment to be effective, the person you appoint must accept the appointment in writing. The person has the right to withdraw from acting as your representative at any time.

This document will continue in effect for a period of five years unless you become incapable. If this occurs, the directive will continue in effect until you are no longer incapable. You have the right to revoke this document in whole or in part at any time you have not been determined to be incapable. **You may not revoke this advance directive when you are determined incapable by two physicians.** A revocation is effective when it is communicated to your treating physician or other provider.

This advance directive will not be valid unless it is signed by two qualified witnesses who are personally known to you and who are present when you sign or acknowledge your signature. Also, it must be accompanied by a written mental status examination performed by a physician or psychologist attesting to your ability to make reasoned decisions about your mental health treatment.

If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you. Attorneys are available through the Mental Health Advocacy Service, 1 (800) 428-5432.

ADVANCE DIRECTIVE FOR MENTAL HEALTH TREATMENT

I, _____, being an adult of sound mind, willfully and
Name of Principal
voluntarily make this advance directive for mental health treatment. I want this directive to be followed if I become incapable. I become "incapable" when two physicians determine that, due to any infirmity, I am currently unable to make or to communicate reasoned decisions regarding my mental health treatment**.**

If I become incapable, I want my mental health treatment decisions to be made: (INITIAL ONLY ONE)

_____ According to the preferences or instructions specifically authorized in this advance directive. I am not appointing a representative at this time.

_____ By my appointed representative according to the preferences or instructions specifically authorized in this advance directive, or, if my desires are not set forth in an advance directive or otherwise known by my representative, in what my representative believes to be my best interest.

1. Designation of Mental Health Treatment Representative.

Each person I appoint must accept my appointment in writing in order to serve as my representative. By law, my representative is authorized to receive information regarding mental health treatment and to receive, review, and authorize disclosure of medical records relating to that treatment, unless limited by federal law or by my advance directive. Limits, or additional directions, if any:_____

_____

_____

I understand that I am not required to appoint a representative in order to complete this advance directive.

I hereby appoint the following person to act as my representative to make decisions regarding my mental health treatment if I become incapable :

Name_____

Address_____

Phone #_____

(*Alternate Representative - - Optional*)

If the person named above refuses or is unable to act on my behalf, or if I revoke that person's authority to act as my representative, I authorize the following person to act as my representative:

Name_____

Address_____

Phone # _____

2. Psychoactive Medications

If it is determined that I am incapable, my wishes regarding psychoactive medications are as follows:

A. The administration of the following medications:

_____
_____
_____
_____
_____

B. The administration of medications considered appropriate by my physician, Dr. _____ , phone # _____ .

C. The refusal of the administration of the following medications. Consider giving reasons. (I understand that my refusal to accept certain medication(s) may be overruled if the medication is medically essential

and the most medically appropriate. This determination is made in an administrative review in which I am provided legal counsel, and is more fully spelled out in R.S. 28:230):

_____
_____
_____
_____
_____

3. Admission to and Retention in Treatment Facility

In the event I become incapable:

A. _____ I hereby authorize my voluntary admission to a mental health
Initial if yes
treatment facility for a period of _____ days (cannot exceed 15 days).

B. Preferences for Treatment (I understand my preferences may not be available):

i. In the event treatment at a treatment facility is necessary, I would prefer to be treated at the following treatment facilities (in order of my preference)

a. _____

b. _____

c. _____

ii. I would prefer not to be treated at the following treatment facilities (consider giving reasons)

a. _____.

b. _____

c. _____

iii. My preference for a treating physician is _____

_____

C. I desire that the following individual(s) be notified immediately when I have been admitted to a mental health treatment facility:

i. Name: _____

Relationship: _____

Phone:_____

ii. Name: _____

Relationship: _____

Phone:_____

4. Electroshock Therapy

A. If it is determined that I am incapable, my wishes regarding electroshock therapy are as follows (consider giving reasons for your decision):

i. _____ I consent to the administration of electroshock therapy. (An involuntary patient must have a hearing before the administration of electroshock therapy, even if he gives consent)

ii _____ I do not consent to the administration of electroshock therapy (consider giving reasons, conditions, and/or limitations):
_____
_____
_____

5. Additional Information

A. I authorize _____ to apply for, and administer,
Name of person
governmental benefits in my name.

B. I give permission for_____ to receive, review,
Name of person
and consent to disclosure of medical records relating to the treatment of my mental illness.

C. Other matters (consider including mental or physical health history, dietary

requirements, religious concerns, and other matters of importance):
_____
_____
_____
_____
_____
_____

YOU MUST SIGN HERE
FOR THIS DIRECTIVE TO BE EFFECTIVE:

_____ _____
Signature *Printed Name and Date*

AFFIRMATION OF WITNESSES

I affirm that the person signing this directive:

(a) Is personally known to me;

(b) Signed or acknowledged his or her signature on this directive in my presence;

(c) Does not appear to be currently unable to make or to communicate reasoned decisions regarding his mental health treatment and does not appear to be under duress, fraud or undue influence;

(d) Is not related to me by blood, marriage, or adoption;

(e) Is not a patient or resident in a facility that I or my relative owns or operates;

(f) Is not my patient and does not receive mental health services from me or my relative; and

(g) Has not appointed me as a representative in this document

Witnessed by:

_____	_____	
Signature	*Printed Name*	*Date*
_____	_____	
Signature	*Printed Name*	*Date*

ACCEPTANCE OF APPOINTMENT AS REPRESENTATIVE

I accept this appointment and agree to serve as a representative to make mental health treatment decisions for _____. I understand that I must act consistently with the desires of the person I represent, as expressed in this directive or, if not expressed, as otherwise known by me. If I do not know the desires of the person I represent, I have a duty to act in what I believe in good faith to be the person's best interest. I understand that this document gives me authority to make decisions about mental health treatment only while that person has been determined to be incapable of making those decisions by two physicians. I understand that the person who appointed me may revoke this directive in whole or in part by communicating the revocation to the treating physician or other provider when the person is not incapable.

Name of Principal

_____ _____

Signature of Representative *Printed Name* *Date*

_____ _____

Signature of Alternative Representative *Printed Name* *Date*

Mental Status Examination

I, the undersigned physician or psychologist, have made an actual

examination of _____, and based on such examination I find that
Name of Principal

_____ :
Name of Principal

- ☐ Demonstrates an awareness of the nature of his illness and situation
- ☐ Demonstrates an understanding of treatment and the risks, benefits, and alternatives; and
- ☐ Communicates a clear choice regarding treatment that is a reasoned one, even though it may not be in his or her best interest.

In summary, _____ has the ability to make reasoned
Name of Principal

decisions regarding his or her mental health treatment.

This signed this _____ day of _____ , 20___.

_____, M.D. or Ph. D. License #_____
Signature

_____
Printed Name

NOTICE TO PHYSICIAN AND/OR PROVIDER OF MENTAL HEALTH TREATMENT

Under Louisiana law, *R.S. 28:221-237 (Act 755 of 2001),* a person may use an advance directive to provide authorization for mental health treatment or to appoint a representative to make mental health treatment decisions when the person is incapable. A person is "incapable" when, in the opinion of two physicians, the person is currently unable to make or to communicate reasoned decisions regarding his or her mental health treatment. This document becomes operative when it is delivered to the person's physician or other provider and remains valid until revoked or expired. It must be signed by the principal and two witnesses and accompanied by a written mental status examination by a physician or psychologist attesting to the principal's ability to make reasoned decisions concerning his mental health treatment.

Upon being presented with this directive, a physician or provider must make it a part of the person's medical record. When acting under authority of the advance directive, a physician or provider must comply with it to the fullest extent possible. The instructions can be disregarded in an emergency if they have not reduced the behavior that has caused the emergency. In a non-emergency, the principal may be medicated contrary to his wishes only after an administrative review, R.S. 28:230. If the physician or provider is unwilling to comply with the advance directive, the physician or provider may withdraw from providing treatment consistent with the law and must promptly notify the person and the person's representative, if any, and document the notification in the person's medical record. A physician or provider who administers or does not administer mental health treatment according to and in good faith reliance upon the validity of this advance directive is not subject to criminal prosecution, civil liability or professional disciplinary action resulting from a subsequent finding of the advance directive's invalidity.

A copy of this and other Louisiana laws can be downloaded from the Louisiana Legislature's home page, http://www.legis.state.la.us/. Click on "Louisiana Laws" and type in the citation. If you have questions about this advance directive, you may contact the Mental Health Advocacy Service at 1 800 428-5432 or the Office of Mental Health at _____ . . .

PHYSICIAN'S CERTIFICATION OF INCAPACITY

I, the undersigned, have made an actual examination of _____ and based on
Name of Principal
such examination I find that _____ :
Name of Principal

☐ Is in need of mental health treatment; and

☐ Is currently unable to make or communicate reasoned decisions regarding his mental health treatment.

I am duly licensed to practice medicine in the state of Louisiana , am not related to _____ by blood, marriage , or adoption, and have no interest in his estate.
Name of Principal

This signed this ____ day of _____ , 20__ , in _____ Louisiana.

_____, M.D. License # _____

PHYSICIAN'S CERTIFICATION OF INCAPACITY

I, the undersigned, have made an actual examination of _____ and based on
Name of Principal
such examination I find that _____ :
Name of Principal

☐ Is in need of mental health treatment; and

☐ Is currently unable to make or communicate reasoned decisions regarding his mental health treatment.

I am duly licensed to practice medicine in the state of Louisiana , am not related to _____ by blood, marriage , or adoption, and have no interest in his estate.
Name of Principal

This signed this ____ day of _____ , 20__ , in _____ Louisiana.

_____, M.D. License # _____