GEORGIA PSYCHIATRIC ADVANCE DIRECTIVE

By: _____ Date of Birth: _____
(Print Name) (Month/Day/Year)

As used in this psychiatric advance directive, the term:

(1) "**Facility**" means a hospital, skilled nursing facility, hospice, institution, home, residential or nursing facility, treatment facility, and any other facility or service which has a valid permit or provisional permit issued under Chapter 7 of Title 31 of the Official Code of Georgia Annotated or which is licensed, accredited, or approved under the laws of any state, and includes hospitals operated by the United States government or by any state or subdivision thereof.

(2) "**Provider**" means any person administering mental health care who is licensed, certified, or otherwise authorized or permitted by law to administer mental health care in the ordinary course of business or the practice of a profession, including, but not limited to, professional counselors, psychologists, clinical social workers, and clinical nurse specialists in psychiatric and mental health; a physician; or any person acting for any such authorized person.

This psychiatric advance directive has four parts:

PART ONE — **STATEMENT OF INTENT AND TREATMENT PREFERENCES**. This part allows you to state your intention for this document and state your mental health treatment preferences and consent if you have been determined to be incapable of making informed decisions about your mental health care. PART ONE will become effective only if you have been determined in the opinion of a physician or licensed psychologist who has personally examined you, 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 you are unable to give or communicate rational reasons for mental health care decisions because of impaired thinking, impaired ability to receive and evaluate information, or other cognitive disability. Reasonable and appropriate efforts will be made to communicate with you about your mental health treatment preferences before PART ONE becomes effective. You should talk to your family and others close to you about your intentions and mental health treatment preferences.

PART TWO — **MENTAL HEALTH CARE AGENT**. This part allows you to choose someone to make mental health care decisions for you when you cannot make mental health care decisions for yourself. The person you choose is called a mental health care agent. You should talk to your mental health care agent about this important role.

PART THREE — **OTHER RELATED ISSUES**. This part allows you to give important information to people who may be involved with you during a mental health care crisis.

PART FOUR — **EFFECTIVENESS AND SIGNATURES**. This part requires your signature and the signatures of two witnesses. You must complete PART FOUR if you have filled out any other part of this form.

You may fill out any or all of the first three parts listed above. You must fill out PART FOUR of this form in order for this form to be effective. You should give a copy of this completed form to people who might need it, such as your mental health care agent, your family, and your physician. Keep a copy of this completed form at home in a place where it can easily be found if it is needed. Review this completed form periodically to make sure it still reflects your preferences. If your preferences change, complete a new psychiatric advance directive. Using this form of psychiatric advance directive is completely optional. Other forms of psychiatric advance directives may be used in Georgia. You may revoke this completed form at any time that you are capable of making informed decisions about your mental health care. If you choose to revoke this form, you should communicate your revocation to your providers, your agents, and any other person to whom you have given a copy of this form. This completed form will supersede any advance directive for health care, durable power of attorney for health care, health care proxy, or living will that you have completed before completing this form to the extent that such other documents relate to mental health care and are inconsistent with the information contained in this form.

(Continued on following page)

PART ONE: STATEMENT OF INTENT AND TREATMENT PREFERENCES

[PART ONE will become effective only if you have been determined in the opinion of a physician or licensed psychologist who has personally examined you, 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 you are unable to give or communicate rational reasons for mental health care decisions because of impaired thinking, impaired ability to receive and evaluate information, or other cognitive disability. Reasonable and appropriate efforts will be made to communicate with you about your mental health treatment preferences before PART ONE becomes effective. PART ONE will be effective even if PARTS TWO or THREE are not completed. If you have not selected a mental health care agent in PART TWO, or if your mental health care agent is not available, then PART ONE will communicate your treatment preferences to your providers or a facility providing care to you. If you have selected a mental health care agent in PART TWO, then your mental health care agent will have the authority to make health care decisions for you regarding matters guided by your mental health treatment preferences and other factors described in this PART.]

(1) STATEMENT OF INTENT

I, (your name) _____, 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 decisions, 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 this 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 directive for health care executed pursuant to Chapter 32 of Title 31 of the Official Code of Georgia Annotated, durable power of attorney for health care creating a health care agency under the former Chapter 36 of Title 31 of the Official Code of Georgia Annotated, as such chapter existed on and before June 30, 2007, 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 a 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 is needed regarding whether or not I am incapable of making mental health care decisions:

_____

_____

_____

The following may cause me to experience a mental health crisis or to make my 448 symptoms worse:

_____

_____

_____

The following techniques may be helpful in de-escalating my crisis:

_____

_____

_____

When I exhibit the following behaviors, I would like to be evaluated to determine whether or not 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: Name and telephone numbers:

_____

_____

_____

I prefer and consent to treatment from the following clinicians:

Names: _____

_____

_____

I refuse to be treated by the following clinicians:

Names: _____

_____

_____

(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 treatment 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 an alternative decision 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 and "no" if you disagree with this statement.) Yes _____ No_____

In the event I need to have medication 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: _____

Liquid medication: Yes _____ No _____
Reason:_____

Medication by injection: Yes _____ No _____
Reason: _____

Covert medication (without my knowledge in drink or food): Yes _____ No _____
Reason:_____

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:

_____

_____

_____

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

Seclusion: Yes _____ No _____
Reason:_____

Physical restraints: 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. This PART 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 you have selected a mental health care agent in PART TWO), or to provide information about your personal and 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 (if you have selected a mental health care agent in PART TWO) 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 such 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 of 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 such 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 in Section (10) of this PART. 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:		
Telephone Number:		
Relationship:		

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: (your name) _____

I accept the designation as agent for: (your name) _____

_____
(Agent's signature and date)

(7) BACK-UP MENTAL HEALTH CARE AGENT(S)

[This section is optional. 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:		
Telephone Number:		
Relationship:		

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:

(your name) _____

I accept the designation as agent for: (your name) _____

_____
(Back-up Agent's signature and date)

Name:		
Address:		
Telephone Number:		
Relationship:		

Second 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:

(your name) _____

I accept the designation as agent for: (your name) _____

_____
(Second Back-up Agent's signature and date)

(Continued on following page)

(8) GENERAL POWERS OF MENTAL HEALTH CARE AGENT

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 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 treatment 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. 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) 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 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 believes 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 AND THERE HAS BEEN A DIVORCE OR ANNULMENT OF OUR MARRIAGE
[Initial if you agree with this statement; leave blank if you do not.]

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

(Continued on following page)

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:		
Telephone Number:		
Relationship:		

Name:		
Telephone Number:		
Relationship:		

(12) HELP FROM OTHERS

The following people are part of my support system (child care, pet care, getting my mail, paying my bills, etc.) and should be contacted in the event of a crisis:

Name:		
Telephone Number:		
Responsibility:		

Name:		
Telephone Number:		
Responsibility:		

Name:		
Telephone Number:		
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 that 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.

_____ (Initials) This psychiatric advance directive will become effective on or

upon (date) _____ and will terminate on or upon (date)_____.

[You must sign and date or acknowledge signing and dating this form in the presence of two witnesses. Both witnesses 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 such 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.]

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 751 willingly and voluntarily.

_____ _____
(Signature of First Witness) (Date)

Print Name:_____

Address:_____

_____ _____
(Signature of Second Witness) (Date)

Print Name:_____

Address:_____