

Planning for Future Mental and Physical Health Care

*Wisconsin Advance Directive and Durable
Power of Attorney for Health Care*

**2nd Edition
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The Wisconsin Coalition for Advocacy and Health Action Network

ANSWERS TO QUESTIONS

Planning for Your Health Care and Treatment

What is an Advance Directive and Power of Attorney for Health Care?

An Advance Directive and Power of Attorney for Health Care is a document you can fill out to indicate your preferences for physical and mental health care if you were unable to make those decisions for yourself. You can name the person that you would want to make those decisions for you, and specify under what situations, and when, your Advance Directive and Power of Attorney becomes effective.

Why should I fill out an Advance Directive and Power of Attorney for Health Care?

The focus for health care is rapidly changing. You know what does and does not work for you when, for example, you are having a mental health crisis. You also have ideas about what measures you would want taken if you were in an "end of life" situation where your death was imminent. When you fill out an Advance Directive and Power of Attorney, you are letting the health care team know what your preferences for treatment are. This can make a major difference in the treatment you receive.

How can I plan ahead?

You can use: (a) the form in this booklet, (b) the statutory power of attorney for health care form which is available from the Wisconsin Department of Health & Family Services, or (c) have your attorney draw one up for you. The form in this booklet was specially created by and for consumers of mental health services and contains a set of instructions focused specifically on mental health issues.

Whichever form you choose will have to be signed by you in the presence of two witnesses. The witnesses cannot be relatives, your doctor, your doctor's staff or any other person (except a chaplain or social worker) at a hospital, clinic or nursing home directly involved with your health care. Nor can any person who is to inherit any money or property from you or who is financially responsible for paying for your health care be a witness.

Can I plan now for the health care treatment I would want if I were in a crisis?

Yes. You can plan now for that time when you may be unable to make your own health care treatment decisions by filling out an Advance Directive and Power of Attorney.

Who decides if I am unable to make my own treatment decisions?

The Advance Directive and Power of Attorney only becomes effective during a period when you are determined to be "incapacitated," or unable to make your own treatment decisions. This determination of "incapacity" can be made in one of three ways as outlined in the Wisconsin Advance Directive and Power of Attorney for Health Care contained in this booklet:

- 1) By two physicians or a physician and a psychologist who have examined you;
- 2) If, due to mental illness, you are determined to be incompetent to refuse medication or treatment under Wisconsin Statutes Chapter 51; or
- 3) You engage in the behaviors, or display the symptoms, or the specific events take place that you list in these Instructions under Section 13.

What kind of planning does the Wisconsin Advance Directive and Power of Attorney for Health Care let me make?

You can indicate what your preferences are regarding mental health care (such as which psychotropic medications worked and/or didn't work for you in the past) or physical care (such as "end of life" instructions) that you may need in the future.

Due to Wisconsin law, there are some decisions that cannot be made with a power of attorney. These include: (a) admission to a psychiatric hospital or unit, (b) long-term admission to a nursing home or group home for persons with mental illness or developmental disabilities, (c) consent to electroshock treatment, and (d) consent to other drastic or experimental treatment.

What can I do if it should ever be decided that I need to have a guardian?

You can use this form to nominate your health care agent or someone else to be your guardian. The court, however, always makes the final decision about who is to be the guardian. If a guardian is appointed, the Advance Directive and Power of Attorney is usually revoked. However, the court can direct that it remain in effect with the health care agent continuing to make decisions for you.

Can I ask someone to speak for me when I am in crisis and can't speak for myself?

Yes! One of the main reasons people choose to fill out an Advance Directive and Power of Attorney is to name a "health care agent," so someone they trust would make the decisions that need to be made when they are unable to. It is a good idea to name an "alternate health care agent" in case the first person cannot do the job.

Do I have to have a lawyer to fill it out?

No. Some people might feel that their Advance Directive and Power of Attorney will be more valid if they use an attorney, but it is not necessary. You can use the form in this booklet.

Can my health care agent make treatment decisions that change my own wishes for treatment?

No! You need to discuss your wishes regarding physical and/or mental health care with the person, and alternate, that you name as your health care agent. One of the reasons you choose a person as your health care agent is because that person will respect your wishes for treatment. However, if a decision needs to be made, and you have not indicated a preference, your health care agent is required to act in your best interest in making that decision. Section 4 shows steps to be followed by your health care agent in making treatment decisions.

If I complete and sign the Wisconsin Advance Directive and Power of Attorney for Health Care, will it be good forever?

Yes, or until you decide to change one of the provisions.

Can anyone help me fill out my Wisconsin Advance Directive and Power of Attorney for Health Care?

Sometimes. You may want to discuss your preferences with your health care professionals. You may recall having major problems with a particular medication, but not remember the name of the medication. You may remember some of your behaviors when you started to go into a crisis, but not remember the early signs or specific medications and procedures that helped you to regain stability. Only you can actually fill out the Advance Directive and Power of Attorney though.

How can I make sure that my instructions will be followed?

When you complete your Advance Directive and Power of Attorney, you should make sure that copies of the completed document are given to your physicians and mental health care providers. Some people feel comfortable giving a copy of their Advance Directive and Power of Attorney to the hospital they use so that the document is attached to their hospital records. Don't forget to give a copy to your health care agent and keep a copy for yourself. If you have an attorney, you may want to give that person a copy also. You should go over your Advance Directive and Power of Attorney section by section, with your doctors and/or treatment providers so that they understand why you have indicated what you listed as your preferences.

Can I change my written instructions for health care treatment or cancel my Wisconsin Advance Directive and Power of Attorney for Health Care?

Yes. Your Advance Directive and Power of Attorney can be revoked if you: (a) tear it up or otherwise destroy it, (b) sign and date a statement revoking it, (c) verbally revoke it in front of two witnesses, or (d) change some of the provisions by making out a new Advance Directive and Power of Attorney. If you do change or revoke your Advance Directive and Power of Attorney, be sure to notify everyone who received a copy of the original document and give them a copy of any new Advance Directive and Power of Attorney that you create.

If I move out of Wisconsin, will my Wisconsin Advance Directive and Power of Attorney for Health Care still be valid?

It depends on where you want to go. Each state has its own rules.

Can anyone force me to make out a Wisconsin Advance Directive and Power of Attorney for Health Care?

NO! No one! No insurance agent, physician, medical or mental health treatment provider, family member, nor anyone else can attempt to force you to complete an Advance Directive and Power of Attorney. Filling out and signing this document must be of your own free will. In fact, the very act of someone trying to force you to complete an Advance Directive and Power of Attorney will invalidate it. The witnesses who sign your Advance Directive and Power of Attorney have to certify that you signed the document in their presence of your own free will.

INSTRUCTIONS

How to Fill Out the Wisconsin Advance Directive and Power of Attorney for Health Care Form

The purpose of this form is to allow you to control decisions about your physical and mental health care if, in the future, you cannot speak for yourself. You can give someone you name (your "Health Care Agent") the power to make health care decisions for you. You can also give instructions about the kind of health care you do or do not want.

Take your time in completing this form. You can either write (legibly), print or type your instructions on this document. Here is a section-by-section guide to, and instructions for, the *Wisconsin Advance Directive and Power of Attorney for Health Care*:

Statutory Notice:

This one page form is required by Wisconsin for all durable powers of attorney for health care that differ from the statutory form.

Sections 1-12:

This is the main body of the form; please read it carefully. Anything you do not agree with, you may change in pen. But . . . you should write your initials near the change and also have your witnesses initial it.

Section 13:

This is where you fill in your health care instructions --

Section A:

Here you can create an additional definition of incapacity. This is primarily in the event that you wish to authorize your health care agent to act on your behalf under a circumstance where you will be legally competent (and not at the end of your life), but you feel you will be effectively mentally incapacitated. You should write "none" if you are satisfied with the definitions in the form.

Section B:

Here is where you list your general treatment instructions. Information such as allergies and medication restrictions are particularly useful to write down. Note that any specific psychotropic medication instructions are better listed in Section D.

Section C:

This is an opportunity for you to consider a few of the areas that are addressed specifically by the Wisconsin statutes. If you are comfortable with the language in Sections 7 to 10, on pages 4 and 5, of the form, check the first block of each item here.

Section D:

These are your mental health instructions, including those for psychotropic medications. Note that item 4 is unusual -- it is a "Statement of Preferences" that you make about your mental health treatment. While these instructions are not legally binding, your preferences can be an important guide to both your health care agent and the professionals who treat you!

Section E:

These are your end-of-life instructions. If you are comfortable with the definition of end-of-life, and wish only non-invasive comfort care, simply initial that definition and fill in "no" for all of the specific treatments and procedures. The organ donation language is identical to the language on the card you receive with your Wisconsin driver's license.

Section 14:

This is where you and your witnesses sign. Two witnesses must observe you signing this Advance Directive and Power of Attorney. They do not need to read this document, but they must read and agree with the paragraph directly above their signature lines before they sign. Note that the witnesses cannot be relatives, your health care providers, beneficiaries of your estate, financially responsible for you, or your health care agent. Your health care agent (and alternate, if you designate one) must also sign this Advance Directive and Power of Attorney in the spaces provided to indicate their consent. They do not need to sign this document in your presence or in the presence of the witnesses.

This Advance Directive and Power of Attorney document takes effect only when you are incapacitated. It is drafted pursuant to Wisconsin Chapter 155, but it is not limited by this statute. Your rights may be broader than the Wisconsin statute, based on the common law rights of self-determination and informed consent, and the rights to liberty under the Wisconsin and United States Constitutions.

This document does not attempt to give legal advice. **IT IS IMPORTANT THAT YOU CAREFULLY READ AND UNDERSTAND THIS DOCUMENT BEFORE YOU SIGN IT.** Your attorney, if you have one, should be consulted before signing, since this form may result in choices that might not be appropriate for you. This form is not the same as the "statutory" form which is printed in the Wisconsin statutes and available from the Wisconsin Department of Health and Family Services.

This is an important paper. Keep the original in a safe place. You should give copies of this Advance Directive and Power of Attorney document to your health care agent (and alternate, if you designate one) and your treatment providers. Write on the last page who, and on what date, you gave copies to. Attached is a cut out of a wallet-sized card for your wallet indicating that you have a health care power of attorney and where it can be found.

You may always change your mind and change or cancel your Advance Directive and Power of Attorney. While there are many ways to do so legally, the best ways are (1) to sign and date a statement in front of a notary revoking all prior Power of Attorney for Health Care documents, or (2) complete a new Advance Directive and Power of Attorney, which automatically revokes any prior versions and instructions. It is very important to give a copy of the "revocation" and/or new Advance Directive and Power of Attorney to your health care agent(s) and health care providers, since they will otherwise not know you have changed your mind.

You can also cancel your Advance Directive and Power of Attorney by tearing up the original documents and all copies, but in the event that any copies are left undestroyed, this can pose a serious problem. Remember, however, if you cancel your Advance Directive and Power of Attorney, that it is especially important to contact any health care agent and alternate agent you have named, and let them know you have revoked the Advance Directive and Power of Attorney.

NOTICE TO PERSONS COMPLETING THE WISCONSIN ADVANCE DIRECTIVE
AND POWER OF ATTORNEY FOR HEALTH CARE

YOU HAVE THE RIGHT TO MAKE DECISIONS ABOUT YOUR HEALTH CARE. NO HEALTH CARE MAY BE GIVEN TO YOU OVER YOUR OBJECTION, AND NECESSARY HEALTH CARE MAY NOT BE STOPPED OR WITHHELD IF YOU OBJECT.

BECAUSE YOUR HEALTH CARE PROVIDERS IN SOME CASES MAY NOT HAVE HAD THE OPPORTUNITY TO ESTABLISH A LONG-TERM RELATIONSHIP WITH YOU, THEY ARE OFTEN UNFAMILIAR WITH YOUR BELIEFS AND VALUES AND THE DETAILS OF YOUR FAMILY RELATIONSHIPS. THIS POSES A PROBLEM IF YOU BECOME PHYSICALLY OR MENTALLY UNABLE TO MAKE DECISIONS ABOUT YOUR HEALTH CARE.

IN ORDER TO AVOID THIS PROBLEM, YOU MAY SIGN THIS LEGAL DOCUMENT TO SPECIFY THE PERSON WHOM YOU WANT TO MAKE HEALTH CARE DECISIONS FOR YOU IF YOU ARE UNABLE TO MAKE THOSE DECISIONS PERSONALLY. THAT PERSON IS KNOWN AS YOUR HEALTH CARE AGENT. YOU SHOULD TAKE SOME TIME TO DISCUSS YOUR THOUGHTS AND BELIEFS ABOUT MEDICAL TREATMENT WITH THE PERSON OR PERSONS WHOM YOU HAVE SPECIFIED. YOU MAY STATE IN THIS DOCUMENT ANY TYPES OF HEALTH CARE THAT YOU DO OR DO NOT DESIRE, AND YOU MAY LIMIT THE AUTHORITY OF YOUR HEALTH CARE AGENT. IF YOUR HEALTH CARE AGENT IS UNAWARE OF YOUR DESIRES WITH RESPECT TO A PARTICULAR HEALTH CARE DECISION, HE OR SHE IS REQUIRED TO DETERMINE WHAT WOULD BE IN YOUR BEST INTERESTS IN MAKING THE DECISION.

THIS IS AN IMPORTANT LEGAL DOCUMENT. IT GIVES YOUR AGENT BROAD POWERS TO MAKE HEALTH CARE DECISIONS FOR YOU. IT REVOKES ANY PRIOR POWER OF ATTORNEY FOR HEALTH CARE THAT YOU MAY HAVE MADE. IF YOU WISH TO CHANGE YOUR POWER OF ATTORNEY FOR HEALTH CARE, YOU MAY REVOKE THIS DOCUMENT AT ANY TIME BY DESTROYING IT, BY DIRECTING ANOTHER PERSON TO DESTROY IT IN YOUR PRESENCE, BY SIGNING A WRITTEN AND DATED STATEMENT OR BY STATING THAT IT IS REVOKED IN THE PRESENCE OF TWO WITNESSES. IF YOU REVOKE, YOU SHOULD NOTIFY YOUR AGENT, YOUR HEALTH CARE PROVIDERS AND ANY OTHER PERSON TO WHOM YOU HAVE GIVEN A COPY. IF YOUR AGENT IS YOUR SPOUSE AND YOUR MARRIAGE IS ANNULLED OR YOU ARE DIVORCED AFTER SIGNING THIS DOCUMENT, THE DOCUMENT IS INVALID.

YOU MAY ALSO USE THIS DOCUMENT TO MAKE OR REFUSE TO MAKE AN ANATOMICAL GIFT UPON YOUR DEATH. IF YOU USE THIS DOCUMENT TO MAKE OR REFUSE TO MAKE AN ANATOMICAL GIFT, THIS DOCUMENT REVOKES ANY PRIOR DOCUMENT OF GIFT THAT YOU MAY HAVE MADE. YOU MAY REVOKE OR CHANGE ANY ANATOMICAL GIFT THAT YOU MAKE BY THIS DOCUMENT BY CROSSING OUT THE ANATOMICAL GIFTS PROVISION IN THIS DOCUMENT.

DO NOT SIGN THIS DOCUMENT UNLESS YOU CLEARLY UNDERSTAND IT.

**WISCONSIN ADVANCE DIRECTIVE AND
POWER OF ATTORNEY FOR HEALTH CARE**

1. CREATION OF POWER OF ATTORNEY FOR HEALTH CARE

This document is my Advance Directive and Power of Attorney for Health Care. I am executing this document voluntarily and while I am of sound mind. Notwithstanding the existence of this document, I am to be fully informed about and allowed to participate in any health care decision for me, to the extent that I am able. This document is intended to be binding on my agent and my health and personal care providers under Wisconsin law, the Federal Patient Self-Determination Act (1990 Public Law No. 101-508, sec 4206 (Medicare) and sec 4751 (Medicaid) and common and constitutional law. By executing this document, I revoke any prior power of attorney for health care that I may have made.

For the purposes of this document, "health care decision" means any decision to accept, maintain, discontinue or refuse any care, treatment, service or procedure to maintain, diagnose or treat my physical or mental condition.

I understand that this document is not the same as the statutory Wisconsin Living Will or the Power of Attorney for Health Care which are distributed by the Wisconsin Department of Health and Family Services.

2. MY HEALTH CARE AGENT

If, due to my incapacity as described below, I am no longer able to make health care decisions for myself, I hereby designate the individual named on the signature page to be my health care agent for the purpose of making health care decisions on my behalf.

If he or she is ever unable or unwilling to do so, I hereby designate the alternate individual named (if any) on the signature page, to be my alternate agent for the purpose of making health care decisions on my behalf. If at any point no agent is available or willing, then I direct that this document be deemed self-executing and binding on any health care provider.

Neither my health care agent nor my alternate health care agent whom I have designated is my health care provider, an employee of my health care provider, an employee of a health care facility in which I am a patient, or a spouse of any of those people, unless he or she is also my relative.

3. WHEN THIS DOCUMENT IS EFFECTIVE

This document is effective upon, and only during, any period in which I am "incapacitated," that is, I am unable due to illness to make health care decisions for myself. This "incapacity" shall exist if one of the following three conditions is met:

(1) Two physicians or a physician and a psychologist who have personally examined me sign a statement that specifically expresses their opinion that I have a condition that means that I am unable to receive and evaluate information effectively or to communicate decisions to such an extent that I lack the capacity to manage my health care decisions; or

(2) Due to mental illness, I am determined under Wisconsin Statutes Chapter 51 to be incompetent to refuse medication or treatment; or

(3) I engage in the behaviors, if any, that I have listed in the attached Instructions, and these behaviors are substantiated in writing by at least two individuals whose names are also listed in the attached Instructions. Their statements must specifically reference this document.

4. GENERAL STATEMENT OF AUTHORITY GRANTED

If I am ever found to be incapacitated, I instruct my health care provider to obtain the health care decision of my health care agent, for all of my health care decisions, subject to the limitations set forth in this document. I have discussed my desires thoroughly with my health care agent and believe that he or she understands my philosophy regarding the health care decisions I would make if I were able. I desire that my wishes be carried out through the authority given to my health care agent under this document.

I direct that my health care agent make any health care decisions for me consistent with my stated wishes, as determined in the following order of priority:

- First*, my health care agent should try to discuss with me any specific proposed health care if I am able to communicate in any manner, including by blinking my eyes.
- Second*, my health care agent should make decisions consistent with the health care wishes expressed in my Instructions in this document and living will ("Declaration to Physicians"), if any.
- Third*, my health care agent should make decisions based upon any health care choices that I have expressed verbally or in other writings prior to the time of the decision.
- Fourth*, my health care agent should make decisions based upon what he or she believes to be in my best interest.

5. SPECIFIC STATEMENT OF AUTHORITY GRANTED

Subject to any limitations in this document, my health care agent has the authority to take such actions and execute such documents on my behalf as he or she deems necessary to carry out his or her authority under this Power of Attorney, including but not limited to the following:

- request, review and receive any information, verbal or written, regarding my physical or mental health, including medical and hospital records;
- execute on my behalf any releases or other documents required to obtain this information
- consent to the disclosure of this information;
- hire and fire medical personnel;
- visit me alone in any hospital or other health care facility (including but not limited to any physical or mental hospital, hospice, nursing home, community-based residential facility, convalescent home or similar establishment), or any other location where I am provided any type of physical or mental health care;
- make all arrangements for me at any health care facility;
- consent to, request, withdraw or refuse medical (including mental health) treatment for me or to require me to be released or transferred from any health care facility; including the authority to sign and amend any documents related to such action, including but not limited to documents titled or purporting to be a "Consent to Permit Treatment," "Refusal to Permit Treatment," or "Leaving Hospital Against Medical Advice";
- sign any waiver or release from liability required by a hospital or physician.

6. LIMITATIONS ON TREATMENT FOR MENTAL DISABILITY

My health care agent may not admit or commit me on an inpatient basis to an institution for mental diseases, an intermediate-care facility for the mentally retarded, a state treatment facility or a treatment facility. My health care agent may not consent to experimental mental health research or psychosurgery, electroconvulsive treatment or drastic mental health treatment procedures for me.

7. ADMISSION TO NURSING HOMES OR COMMUNITY-BASED RESIDENTIAL FACILITIES

My health care agent may admit me to a nursing home or community-based residential facility, both as defined in Wisconsin Statute 155.20(2)(c). However, if I am diagnosed as mentally ill or developmentally disabled, my health care agent may admit me to a nursing home or a community-based residential facility solely for short-term stays for recuperative care (maximum 3 months) or respite care (maximum 30 days). [Please note the special section of the Instructions for limitations on this authority.]

8. PROVISION OF NUTRITION AND HYDRATION

My health care agent may have artificially or technologically supplied nutrition and hydration (e.g., feeding tubes) withheld or withdrawn from me, unless my physician has advised that, in his or her professional judgment, this will cause me pain or will reduce my comfort. [Please note the special section of the Instructions for limitations on this authority.]

My health care agent may not consent to the withdrawal of orally ingested nutrition or hydration unless provision of the nutrition or hydration is medically contraindicated.

9. HEALTH CARE DECISIONS FOR PREGNANT WOMEN

My health care agent may make health care decisions for me even if my agent knows I am pregnant, and I intend that this override any restriction imposed by state law on my living will. [Please note the special section of the Instructions for limitations on this authority.]

10. GUARDIANSHIP

Should any court be asked to appoint a guardian or similar representative for me, I nominate and request that my agent under this health care power of attorney be appointed to serve as such guardian or representative. [Please note the special section of the Instructions for nominating someone else as guardian.] I additionally ask the court to strongly consider my wishes, while I am of sound mind, that this power of attorney remain in effect and my health care agent continue to have the power specified herein, even if my health care agent is not my appointed guardian.

11. REVOCATION OF THIS POWER OF ATTORNEY

I may revoke this power of attorney at any time by doing any of the following: (1) destroying it; (2) signing a statement revoking it; (3) verbally revoking it in the presence of two witnesses; (4) executing a subsequent power of attorney for health care; or (5) in any other manner permitted by law.

12. CONFLICTS BETWEEN THIS POWER OF ATTORNEY, MY STATEMENT OF INSTRUCTIONS AND MY LIVING WILL; UNENFORCEABILITY OF ANY DIRECTION; COPIES VALID

Any conflicts between this form, my Instructions and my living will shall be resolved according to the following priority: first in favor of my Instructions, second in favor of the living will, and third in favor of this form power of attorney. This priority shall be regardless of the order the documents were created in (for example, even if my living will was executed one year after this form with its Instructions, the Instructions shall still override any conflicting provisions in the living will.)

If any of the specific directions in this document are held unenforceable, I intend that the remainder of this document be given full force and effect. A photocopy of this executed document shall be given the same legal force as the original document.

13. HEALTH CARE INSTRUCTIONS

Leaving any or all of the items blank does not in any way invalidate this document. Also, the headings below are for convenience only and in no way limit these instructions. For example, it does not matter whether an instruction with regard to a psychotropic medication is listed under "Medication," "Psychotropic Medication," "Other Specific Treatment Instructions," or any other area of these instructions. Separate pages of instructions may be attached if appropriate.

A. Definition of Incapacity

Pursuant to my rights under Wisconsin Statute 155.05(2), the following shall also be conclusive evidence of my incapacity for purposes of this document only:

I engage in the following behaviors, or exhibit the following symptoms, or the following events take place:

and this is substantiated in writing by the following people (there must be at least two people):

Their statements must be attached to this document.

B. General Treatment Instructions

(1) Useful Background Information (e.g., allergies, conditions, history)

(2) Medications (for Psychotropic Medications, see Mental Health Instructions below)

a. The following medications may not be given to me:

Medication	Reason to avoid
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

b. Other than the above medications, medications may be given to me only in consultation with my agent. I specifically instruct my agent to consent to the following medications under the following circumstances:

Medication	Dosage	To be given under these circumstances
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

c. My agent may consent to other medications (except those listed in a. above) following the standards in the General Statement of Authority Granted (Section 4., above).

(3) Other General Treatment Instructions

C. Special Limitations

(1) Limitations on Authority to Admit Me to Nursing Home (check only one)

- No limitations (other than those in Section 7 or imposed by law).
- I authorize my agent to consent to my admission to a nursing home only for short-term stays for recuperative care (maximum 3 months) or respite care (maximum 30 days).
- I do not authorize my agent to consent to my admission to a nursing home.

(2) Limitations on Authority to Admit Me to Community-Based Residential Facility (CBRF) (check only one)

- No limitations (other than those in Section 7 or imposed by law).
- I authorize my agent to consent to my admission to a CBRF only for short-term stays for recuperative care (maximum 3 months) or respite care (maximum 30 days).
- I do not authorize my agent to consent to my admission to a CBRF.

(3) Limitations on Authority to Withdraw Feeding Tube (check only one)

- No limitations (other than those in Section 8 or imposed by law).
- I do not authorize my agent to have a feeding tube withdrawn or withheld from me.

(4) Limitations on Authority if I am Pregnant (check only one)

- No limitations (other than those in Section 9 or imposed by law).
- I do not authorize my agent to make health care decisions if I am pregnant.

(5) Nomination of Guardian or representative if ever necessary (check only one)

- I nominate my agent under my health care power of attorney (as stated in Section 10).
- I nominate the following person (fill in name, address and phone):

D. Mental Health Instructions

(1) Psychotropic Medications

a. The following psychotropic medications may not be given to me:

Medication	Reason to avoid
_____	_____
_____	_____
_____	_____
_____	_____

b. Other than the above psychotropic medications, psychotropic medications may be given to me only in consultation with my agent. I specifically instruct my agent to consent to the following psychotropic medications under the following circumstances:

Medication	Dosage	To be given under these circumstances
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

c. My agent may consent to other psychotropic medications (except those listed in a. above) following the standards in the General Statement of Authority Granted. (Section 4., above).

(2) Other Forms of Mental Health Treatment

a. I authorize my agent to consent to the following types of mental health treatment for me:

b. The following types of mental health treatment may not be given to me:

(3) Additional Instructions Regarding Mental Health Care or Treatment

(4) Statement of Preferences Regarding Mental Health Care and Treatment

I understand that the following is a statement of my preferences regarding mental health care and treatment. I cannot require my agent or mental health professionals to follow these statements. However, I strongly hope that these statements will be honored to assist me in having more control over my life and to aid in my recovery.

a. Hospitals and Community Treatment Programs (outpatient clinics, community-based residential facilities, community support programs, etc.)

I would like to receive treatment from the following hospitals and community treatment programs: _____

I do not want to receive treatment from the following hospitals or community treatment programs: _____

b. Mental Health Care Professionals

My mental health care professionals are:

Name	Phone Number	Area of Expertise
------	--------------	-------------------

_____	_____	_____
_____	_____	_____
_____	_____	_____

Mental health care professionals whom I do not want involved in my treatment are:

Name	Reason, if any
------	----------------

_____	_____
_____	_____
_____	_____

(4) Statement of Preferences Regarding Mental Health Care and Treatment (continued)

c. Approaches That Help Me When I'm Having a Hard Time.

If I am having a hard time, the following approaches have been helpful in the past. I would like staff to try to use these approaches with me.

- | | |
|---|--|
| <input type="checkbox"/> Voluntary time out in my room | <input type="checkbox"/> Listening to music |
| <input type="checkbox"/> Voluntary time out in quiet room | <input type="checkbox"/> Reading a newspaper/book |
| <input type="checkbox"/> Sitting by staff | <input type="checkbox"/> Watching T.V. |
| <input type="checkbox"/> Talking with another consumer | <input type="checkbox"/> Pacing the halls |
| <input type="checkbox"/> Talking with staff | <input type="checkbox"/> Calling a friend |
| <input type="checkbox"/> Having my hand held | <input type="checkbox"/> Calling my therapist |
| <input type="checkbox"/> Having a hug | <input type="checkbox"/> Pounding some clay |
| <input type="checkbox"/> Punching a pillow | <input type="checkbox"/> Exercise |
| <input type="checkbox"/> Writing in a diary/journal | <input type="checkbox"/> Using ice on my body |
| <input type="checkbox"/> Deep breathing exercises | <input type="checkbox"/> Putting hands under cold water |
| <input type="checkbox"/> Going for a walk with staff | <input type="checkbox"/> Lying down with cold face cloth |
| <input type="checkbox"/> Taking a hot shower | <input type="checkbox"/> Wrapping up in a blanket |

Other (Please list) _____

d. Actions That Are Not Helpful

In the past I have found that the following actions make me feel worse. I prefer that staff not do the following:

(4) Statement of Preferences Regarding Mental Health Care and Treatment (continued)

e. If I Am Admitted to a Hospital I Have the Following Preferences:

(1) Emergency Measures

If I am dangerous to myself or someone else such that an emergency intervention is necessary, I prefer the following methods be used.

(Instruction: Number according to preference: 1, 2, 3, 4, 5)

- | | |
|---|--|
| <input type="checkbox"/> Seclusion alone | <input type="checkbox"/> Oral medication |
| <input type="checkbox"/> Physical restraint alone | <input type="checkbox"/> Medication by injection |
| <input type="checkbox"/> Seclusion and physical restraint | <input type="checkbox"/> Other: |

(2) Strip Searches/Body Cavity Searches [Check all items that apply.]

- If I must be searched I have a preference that the search be conducted by a staff person who is the same sex as I am.
- I do not care if the staff member conducting the search is male or female.
- If a search is conducted I want the staff to notify my health care agent.

(3) Special Consideration Regarding Touch/Body Space [Check all items that apply.]

- I do wish to be touched.
- I do not wish to be touched.
- I wish to be asked permission before being touched.
- I wish to be told reasons why I am being touched.
- I wish special attention be given to allowing me extra personal body space.
- I do not need special attention given to my body space.

f. Additional Preferences or Limitations Regarding my Mental Health Care or Treatment

E. End-of-Life Instructions

End-of-Life Definition: If I have selected one of the following two "end of life" definitions, it is because, although I greatly value life, I also believe that at some point life has such diminished value that treatment other than comfort care should be stopped, and I should be allowed to die. (Comfort care includes pain medications even if those medications may dull my consciousness or shorten my life.) Insert your initials before the definition below that appropriately defines that point in time for you:

_____ When two licensed physicians have personally examined me and determined in writing that either (1) I am in a terminal condition or a persistent vegetative state as defined by state law; or (2) I have an incurable and irreversible condition, including a coma, from which there is no reasonable hope of recovery.

_____ My own definition is as follows: _____

Specific End-of-Life Treatments and Procedures: Follow each of the following choices with "Yes" (I want if medically appropriate), "No" (I don't want), "Try" (try, but if no clear improvement, stop), or "Don't know" (I don't know at this time). Spaces left blank are assumed to be "Don't Know." Add any notes you feel appropriate.

Cardiopulmonary resuscitation (chest compression, drugs, electric shocks and artificial breathing aimed at reviving a person who is on the point of dying): _____

Major surgery (for example, removing the gall-bladder or part of the colon): _____

Mechanical breathing respiration by machine (through a tube in the throat): _____

Dialysis (cleaning the blood by machine or by fluid passed through the belly): _____

Blood transfusions or blood products: _____

Artificial nutrition and hydration (given through a tube in a vein or in the stomach): _____

Invasive diagnostic tests (e.g., using a flexible tube to look into the stomach): _____

Other (fill in): _____

Upon my death:

_____ I wish to donate only the following organs or parts: (specify the organs or parts).

_____ I wish to donate any needed organ or part.

_____ I wish to donate my body for anatomical study if needed.

_____ I refuse to make an anatomical gift. (If this revokes a prior commitment that I have made to make an anatomical gift to a designated donee, I will attempt to notify the donee to which or to whom I agreed to donate.)

Failing to check any of the lines immediately above creates no presumption about my desire to make or refuse to make an anatomical gift.

Signature: _____

Date: _____

