ADVANCE MENTAL HEALTH CARE DIRECTIVE AND DURABLE POWER OF ATTORNEY

I, _____,

Print Name

herby direct that _____,

Print Name

make all mental health treatment decisions for me, as further described below.

EXPLANATION

You have the right to give instructions about your own mental health care. You also have the right to name someone else to make mental health treatment decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding the designation of your health care providers. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Part 1 of this form is a list of options you may designate as part of your mental health care and treatment. For ease of designating specific instructions, mark those options in Part 1.

Part 2 of this form is a power of attorney for mental health care. This lets you name another individual as your agent to make mental health treatment decisions for you, if you become incapable of making your own decisions, or if you want someone else to make those decisions for you now, even though you are still capable of making your own decisions. You may name alternate agents to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. Unless related to you, you r agent may not be an owner, operator, or employee of a health care institution where you are receiving care. You may allow your agent to make all mental health treatment decisions for you. However, if you wish to limit the authority of your agent, you may specify those limitations on the form. If you do not limit the authority of your agent, your agent will have the right to take actions including the following:

(1) Consent or refuse to consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a mental condition;
(2) Select or discharge health care providers and institutions;
(3) Approve or disapprove diagnostic tests, surgical procedures, and programs of medication; and
(4) Approve or disapprove of electroconvulsive treatment.

Part 3 of this form lets you give specific instructions about any aspect of your mental health care and treatment. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of medication and treatment. Space is provided for you to add to the choices you have made or for you to write out any additional wishes. Part 4 of this form must be completed in order to activate the advance mental health care directive. After completing this form, sign and date the form at the end and have the form witnessed by one or both of the two methods listed below. Give a copy and the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any mental health care agents you have named. You should talk to the persons you have named as agents to make sure that they understand your wishes and are willing to take the responsibility. You have the right to revoke this advance mental health care directive or replace this form at any time, unless otherwise specified in writing in the advance mental health care directive.

PART 1

CHECKLIST OF MENTAL HEALTH CARE OPTIONS

NOTE TO PROVIDER: The following is a checklist of selections I have made regarding my mental health care and treatment. I include this statement to express my strong desire for you to acknowledge and abide by my rights, under state and federal laws, to influence decisions about the care I will receive.

Power of Attorney (Part 2)

1. Designation of my mental health care agent (s).
2. Authority granted to my agent (s).
3. My preference for a court appointed guardian.

Directive for Mental Health Care (Part 3)

4. My preference of treating facility and alternatives to hospitalization.
5. My preferences about the physicians or other mental health care providers who will treat me if I am hospitalized.
6. My preferences regarding medications.
7. My preferences regarding electroconvulsive therapy (ECT or shock treatment).
8. My preferences regarding emergency interventions (seclusion, restraint, medications).
9. Consent for experimental drugs of treatments.
10. Who should be notified immediately of my admission to a facility.
11. Who should be prohibited from visiting me.
12. My preferences for care and temporary custody of any of my children or pets.
12. Other instructions about mental health care and treatment.

PART 2

DURABLE POWER OF ATTORNEY FOR MENTAL HEALTH TREATMENT DECISIONS

1. DESIGNATION OF AGENT: I designate the following as my agent to make mental health care decisions for me:

(name)

(address) (city) (state) (zip code)

(home phone) (work phone)

2. AGENT'S AUTHORITY: My agent is authorized to make all mental health care treatment decisions for me, including decisions to provide, withhold, or withdraw medication and treatment, and all other forms of mental health care.

My agent's authority becomes effective when my supervising health care provider who is a physician and one other physician or licensed psychologist determine that I am unable to make my own mental health care decisions.

My agent shall make mental health care decisions for me in accordance with this power of attorney for mental health care, any instructions I give in this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make mental health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

3. NOMINATION OF GAURDIAN: If a guardian needs to be appointed for me by the court, I nominate the agent designated in this form.

PART 3

INSTRUCTIONS FOR MENTAL HEALTH CARE AND TREATMENT

In accordance with the Power of Attorney above (Part2), I entrust to my agent all mental health care decisions for me, specifically including, but not limited to, the following:

4. My preference of treating facility and alternatives to hospitalization:
5. My preferences about the physicians or other mental health care providers who will treat me if I am hospitalized:
6. My preferences regarding medications:
7. My preferences regarding electroconvulsive therapy (ECT or shock treatment);
8. My preferences regarding emergency interventions (seclusion, restraint, medications);
9. Consent for experimental drugs or treatments;
10. Who should be notified immediately of my admission to a facility;
11. Who should be prohibited from visiting me;
12. My preferences for care and temporary custody of my children or pets; and
13. My preferences about revocation of my advance mental health care directive during a period of incapacity.

PART 4

WITNESSES AND SIGNATURES

EFFECT OF COPY: A copy of this form has the same effect as the original.

CAPACITY: I am at least 18 years of age, no court has declared me to be incapacitated or appointed a legal guardian to care for me, and I am not currently under an involuntary commitment.

SIGNATURES:

_____ _____

(sign your name) (date)

_____

(address)

_____

(city) (state) (zip)

AFFIRMATION OF WITNESS

Witness 1

I declare under penalty of false swearing pursuant to section 710-1062, Hawaii Revised Statues, that the principal is personally known to me, that the principal signed or acknowledged this power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as agent by this document, and that I am not a health care provider, nor an employee of a health care provider or facility. I am not related to the principal by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

_____ _____

(sign your name) (date)

_____

(print your name)

_____

(address)

_____

(city) (state) (zip)

Witness 2

I declare under penalty of false swearing pursuant to section 710-1062, Hawaii Revised Statues, that the principal is personally known to me, that the principal signed or acknowledged this power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as agent by this document, and that I am not a health care provider, nor an employee of a health care provider or facility. I am not related to the principal by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

_____ _____

(sign your name) (date)

_____

(print your name)

_____

(address)

_____

(city) (state) (zip)