CALIFORNIA MENTAL HEALTH POWER OF ATTORNEY FORM

IMPORTANT INFORMATION

This power of attorney authorizes another person (your agent) to make decisions for you (the principal). Your agent will be able to make decisions and act on your behalf, whether or not you are able to act for yourself.

This power of attorney does not authorize the agent to make health care decisions for you. Such powers are governed by applicable laws for Advance Directives.

You should select someone you trust to serve as your agent. Unless you specify otherwise, generally the agent's authority will continue until you die or revoke the power of attorney or the agent resigns or is unable to act for you.

If your agent is unable or unwilling to act for you, your power of attorney will end unless you have named a successor agent. You may also name a second successor agent.

This power of attorney becomes effective immediately unless you state otherwise in the Special Instructions.

If you have questions about the power of attorney or the authority you are granting to your agent, you should seek legal advice before signing this form.

The following forms are available from the National Resource Center on Psychiatric Advance Directives.

Advance Health Care Directive of _____

(Your name)

Instructions Included in My Directive

Put a check mark in the left-hand column for each section you have completed.

#	**PART I** **Appointment of an Agent for Healthcare**
1	Designation of Health Care Agent Designation of Alternate Health Care Agent
2	Authority Granted to My Agent
3	My choice as to a Court Appointed Conservator
#	**PART II(a)** **Statement of Individual Mental Health Care Instructions**
4	Who, In Addition to My Health Care Agent, Should Be Notified Immediately of My Admission To a Psychiatric Facility?
5	My Choice of Treatment Facility and Choices for Alternatives to Hospitalization If 24-Hour Care is Deemed Medically Necessary for My Safety and Well-being
6	My Primary Physician who is to Have Primary Responsibility for my Mental Health Care is:
7	My Choices about primary Physicians Who Will Treat Me if I Am Hospitalized and my Primary Physician is Unavailable
8	My Choices Regarding Methods for Avoiding Emergency Situations
9	My Choices Regarding Emergency Interventions
9(a)	My Choices Regarding **Routine** Medications for Psychiatric Treatment
9(b)	My Choices Regarding **Emergency** Psychiatric Medication
10	My Choices Regarding Electroconvulsive Therapy
11	The Following People Are to be Prohibited from Visiting Me
12	Other Instructions About Mental Health Care
#	**PART II(b)** **Individual Physical Health Care Instructions**

Advance Health Care Directive of _____

(Your name)

PART I
APPOINTMENT OF AN AGENT FOR HEALTH CARE **MAKE SURE YOU GIVE YOUR AGENT A COPY OF ALL SECTIONS OF THIS DOCUMENT**

If no agent is designated under the Power of Attorney for Health Care section of this document, or if the agent cannot be located, health care providers must still follow any Individual Health Care Instructions contained in this document. Cal. Probate Code Sections 4670, 4671. An agent has priority over any other person in making health care decisions for the patients. Cal. Probate Code Section 4685.

STATEMENT OF INTENT TO APPOINT AN AGENT:

I, (*your name*) _____, being of sound mind, authorize a health care agent to make certain decisions of my behalf regarding my health treatment when I am incompetent to do so unless I mark this box ⑤, in which case my agent's authority to make health care decisions for me takes effect immediately. I intend that those decisions should be made in accordance with my expressed wishes as set forth in this document. If I have not expressed a choice in this document, I authorize my agent to make the decision that my agent determines is the decision I would make if I were competent to do so.

1. Designation of Health Care Agent

A. I hereby designate and appoint the following person as my agent to make health care decisions for me as authorized in this document. This person is to be notified immediately of my admission to a psychiatric facility.

Name: _____

Address: _____

City, State, Zip Code:_____

Day Phone: _____ Evening Phone: _____

Pager: _____ Cell Phone:_____

Designation of Alternate Health Care Agent

If the person named above is unavailable, unable or unwilling to serve as my agent, I hereby appoint and desire immediate notification of my alternative agent as follows:

Name: _____

Address: _____

City, State, Zip Code:_____

Day Phone: _____ Evening Phone: _____

Pager: _____ Cell Phone:_____

2. Authority Granted to My Agent

If I become incapable of giving informed consent to health care treatment, or if I marked the box under "Statement of Intent to Appoint an Agent" causing my agent's authority to make decisions for me to immediately become effective, I hereby grant to my agent full power and authority to make health care decisions for me, including the right to consent, refuse consent, or withdraw consent to any health care, treatment, service or procedure, consistent with any instructions and/or limitations I have set forth in this advance directive EXCEPT as I state here. If I have not expressed a choice in this advance directive, I authorize my agent to make the decision that my agent determines is the decision I would make if I were competent to do so.

_____

_____

_____

_____

_____

_____

3. My Choice as to a Court-Appointed Conservator

In the event a court decides to appoint a conservator who will make decisions regarding my health treatment, I desire the following person to be appointed:

Name: _____ Relationship:_____

Address: _____

City, State, Zip Code:_____

Day Phone: _____ Evening Phone: _____

Pager: _____ Cell Phone:_____

The appointment of a conservator or other decision maker shall not give the conservator or decision maker the power to revoke, suspend, or terminate my individual health care instructions or the powers of my agent.

****MAKE SURE YOU GIVE YOUR AGENT AND ALTERNATE AGENT A COPY OF ALL SECTIONS OF THIS DOCUMENT****

Advance Health Care Directive of _____

(Your name)

PART II(a)
STATEMENT OF INDIVIDUAL
MENTAL HEALTH CARE INSTRUCTIONS

In this part, you state how you wish to be treated (such as which hospital you wish to be taken to, which medications you prefer) if you become incapacitated or unable to express your own wishes. If you want a paragraph to apply, put your initials before the paragraph letter. If you do not want the paragraph to apply to you, leave the line blank.

NO INDIVIDUAL MENTAL OR PHYSICAL HEALTH CARE INSTRUCTION CONTAINED IN THIS DOCUMENT MAY BE CARRIED OUT AGAINST MY WISHES.

4. Who, In Addition to My Health Care Agent, Should Be Notified Immediately of My Admission To a Psychiatric Facility? *Be sure to include the agent and any alternate agent you designate in your Durable Power of Attorney, if you have one.*

Name: _____
Address: _____
City, State, Zip Code:_____
Day Phone: _____ Evening Phone: _____
Pager: _____ Cell Phone:_____

Name: _____
Address: _____
City, State, Zip Code:_____
Day Phone: _____ Evening Phone: _____
Pager: _____ Cell Phone:_____

Name: _____
Address: _____
City, State, Zip Code:_____
Day Phone: _____ Evening Phone: _____
Pager: _____ Cell Phone:_____

Name: _____
Address: _____
City, State, Zip Code:_____
Day Phone: _____ Evening Phone: _____
Pager: _____ Cell Phone:_____

5. My Choice of Treatment Facility and Choices for Alternatives to Hospitalization If 24-Hour Care is Deemed Medically Necessary for My Safety and Well-being

____ A. In the event my psychiatric condition is serious enough to require 24hour care and I have no physical conditions that require immediate access to emergency medical care, I would prefer to receive this care at the following programs/facilities instead of psychiatric hospitalization.

Facility's Name: _____
Reason: _____
Facility's Name: _____
Reason: _____
Facility's Name: _____
Reason: _____

____ B. In the event I am to be admitted to a hospital for 24-hour care, I would prefer to receive care at the following hospitals:

Facility's Name: _____
Reason: _____
Facility's Name: _____
Reason: _____
Facility's Name: _____
Reason: _____

____ C. I do not wish to be admitted to the following hospitals or programs/facilities for psychiatric care for the reasons I have listed:

Facility's Name: _____
Reason: _____
Facility's Name: _____
Reason: _____
Facility's Name: _____
Reason: _____

6. My Primary Physician who is to Have Primary Responsibility for my Mental Health Care is:

Dr. _____ Phone _____

Address _____ Pager _____

City, State, Zip _____ _____

7. My Choices about the Physicians Who Will Treat Me if I Am Hospitalized and my Primary Physician is Unavailable

Put your initials before the letter and complete if you wish either or both paragraphs to apply.

____ A. My choice of treating physician if the above physician is unavailable is:

Dr._____ Phone _____

Address _____

OR if neither is available

Dr._____ Phone _____

OR if none of the above is available

Dr._____ Phone _____

____ B. I do not wish to be treated by the following, for the reasons stated:

Dr._____ Reason:_____

OR _____

Dr._____ Reason:_____

OR _____

Dr._____ Reason:_____

_____

8. My Choices Regarding Methods for Avoiding Emergency Situations

If during my admission or commitment to a mental health treatment facility it is determined that I am engaging in behavior that **may** make emergency intervention necessary, I prefer the following choices to help me regain control:

Fill in numbers, giving 1 to your first choice, 2 to your second, and so on until each has a number. If your choice is not listed, write it in after "other" and give it a number as well.

⑨ Provide a quiet private place

⑨ Have a staff member of my choice talk with me one-on-one

⑨ Allow me to engage in physical exercise

⑨ Offer me recreational activities

⑨ Assist me with telephoning a friend or family member

⑨ Offer me the opportunity to take a warm bath

⑨ Offer me medication

⑨ Offer me a cigarette

⑨ Allow me to go outside

⑨ Provide me with materials to journal or do artwork

⑨ Offer me assistance with breathing or calming exercises

⑨ Provide me with a radio to listen to

⑨ Other: _____

_____

_____

_____

9. My Choices Regarding Emergency Interventions

If, during an admission or commitment to a mental health treatment facility, it is determined that I am engaging in behavior that requires an emergency intervention (e.g., seclusion and/or physical restraint and/or medication), my wishes regarding which form of emergency interventions should be made as follows. I prefer these interventions in the following order:

Fill in numbers, giving 1 to your first choice, 2 to your second, and so on until each has a number. If an intervention you prefer is not listed, write it in after "other" and give it a number as well. If you do not want a listed intervention ever used, cross it out and explain why under "Reasons for my choices."

	Reasons for my choices
⑨ Seclusion	_____
⑨ Physical restraints	_____
⑨ Seclusion and physical restraint (combined)	_____
⑨ Medication by injection	_____
⑨ Medication in pill form	_____
⑨ Liquid medication	_____
⑨ During seclusion and/or restraint, I prefer to be checked by **female** staff	_____
⑨ During seclusion and/or restraint, I prefer to be checked by **male** staff	_____
⑨ Other:_____	_____
_____	_____

See Section 9(b) for choices regarding emergency medication

I expect the choice of medication in an emergency situation to reflect any choices I have expressed in this section and in Section 9(b). **The choices I express in this section and Section 9(b) regarding medication in emergency situations do not constitute consent to use of the medication for non-emergency treatment**.

9(a). My Choice Regarding *Routine* Medications for Psychiatric Treatment

In this section, you may choose any of the paragraphs A-G that you wish to apply. Be sure to initial those you choose.

If it is determined that I am not legally competent to consent to or to refuse medications relating to my mental health treatment, my wishes are as follows:

____ A. I consent to the medications agreed to by my agent, after consultation with my treating physician and any other individuals my agent may think appropriate, with the reservations, if any, described in (D) below.

____ B. authorize my agent to consent

Medication Name or Medication Type	**Not to exceed the following dosage/day**	**OR**	**In such dosage(s) as determined by**
_____	_____		Dr. _____
_____	_____		Or if unavailable, then by
_____	_____		Dr. _____
_____	_____		
_____	_____		
_____	_____		
_____	_____		
_____	_____		

____ C. I consent to the medications deemed appropriate by Dr. _____ , whose address and phone number are: _____
_____

9(a) Continued

____ D. I specifically do not consent and I do not authorize my agent to consent to the administration of the following medications or their respective brand name, trade name, or generic equivalents:

Name of Drug	**Reason for Refusal**
_____	_____
	_____
_____	_____
	_____
_____	_____
	_____
_____	_____
	_____

____ E. I am willing to take the medications excluded in (D) above if my only reason for excluding them is their side effects and the dosage can be adjusted to eliminate those side effects.

____ F. I am concerned about the side effects of medications and do ***not*** consent or authorize my agent to consent to any medication that has any of the side effects I have checked below at 1% or greater level of incidence (*check all that apply)*.

⑨ Tardive dyskinesia ⑨ Tremors

⑨ Loss of Sensation ⑨ Nausea/vomiting

⑨ Motor Restlessness ⑨ Neuroleptic Malignant Syndrome

⑨ Seizures ⑨ Other _____

⑨ Muscle/skeletal rigidity

_____

____ G. I have the following other choices about psychiatric medications:

_____

_____

9(b) My Choices Regarding *Emergency* Psychiatric Medication

If during my admission or commitment to a mental health facility, it is determined that I am engaging in behavior that requires emergency psychiatric medication, I prefer the following medication:

Medication Name or Medication Type	**Not to exceed the following dosage/day**	**OR**	**In such dosage(s) as determined by**
_____	_____		Dr. _____
_____	_____		
_____	_____		Or if unavailable, then by
_____	_____		
_____	_____		Dr. _____
_____	_____		
_____	_____		
_____	_____		

The choices expressed in this section regarding medication in emergency situations do not constitute consent to use of the medication for nonemergency treatment.

10. My Choices Regarding Electroconvulsive Therapy

____ A. I **do not** consent to administration of electroconvulsive therapy.

B. Under California law, this Directive **cannot** be used to consent for electroconvulsive therapy. However, if I am administered electroconvulsive therapy, I have the following choices:

⦾ I will be administered no more than the following number of treatments _____ .

⦾ I will be administered the number of treatments deemed appropriate by Dr. _____, whose phone number and address is:

_____.

11. The Following People Are to be Prohibited from Visiting Me:

Name	**Relationship**
_____	_____
_____	_____
_____	_____
_____	_____

12. Other Instructions About Mental Health Care

_____

_____

_____

_____

_____

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_____

_____

_____

_____

(You may attach additional pages if you need more space to complete your statement. If you attach additional pages, you must sign and date EACH of the additional pages at the same time you sign and date this document.)

Advance Health Care Directive of _____

(Your name)

PART II(b)
INDIVIDUAL PHYSICAL HEALTH CARE INSTRUCTIONS

NO INDIVIDUAL MENTAL OR PHYSICAL HEALTH CARE INSTRUCTION CONTAINED IN THIS DOCUMENT MAY BE CARRIED OUT AGAINST MY WISHES

13. My Primary Physician who is to have primary responsibility for my physical health care is:

Dr._____ Phone

_____ Address _____

Pager_____

City, State, Zip Code:_____

OR if the above physician is unavailable, then I request:

Dr._____ Phone _____

Address: _____

City, State, Zip Code:_____

OR if neither of the above is available, then I request:

Dr._____ Phone _____

Address: _____

City, State, Zip Code:_____

I specifically do not want to be treated by the following physicians:

Dr._____ Reason:_____

OR _____

Dr._____ Reason:_____

OR _____

Dr._____ Reason:_____

_____

14. Statement of Desires, Special Provisions and Limitations

____ A. I specifically express the following desires concerning these health care decisions:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

____ B. And I specifically limit this Advance Directive as follows:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

(You may attach additional pages if you need more space to complete your statement. If you attach additional pages, you must sign and date EACH of the additional pages at the same time you sign and date this document.)

15. My Choices Regarding Experimental Studies and Drug Trials

⑨ I **will not** participate in experimental studies or drug trials.

Under recent changes to California law, a health care agent, if one has been appointed, a conservator, a family member, or domestic partner may consent to participation in a medical experiment on behalf of a person who is unable to consent under very specific circumstances. See Health and Safety Code, section 24178 for a list of these specific circumstances.

Complete this section **only** if you do not consent to participation in medical experiments under any circumstances.

16. My Instructions Regarding Life Sustaining Treatment

____ A. I **do not** want my life to be prolonged and I **do not** want life-sustaining treatment to be provided or continued: (1) if I am in an irreversible coma or persistent vegetative state; or (2) if I am terminally ill and the application of life sustaining procedures would serve only to artificially delay the moment of my death; or (3) under any other circumstances where the burdens of treatment outweigh the expected benefits. I want the relief of suffering and the quality as well as the possible extension of my life considered in making decisions concerning life-sustaining treatment.

OR

____ B. I want my life to be prolonged and I want life sustaining treatment to be provided **unless I am in a coma or vegetative state** which my doctor reasonably believes to be irreversible. Once my doctor has reasonably concluded that I will remain unconscious for the rest of my life, I **do not** want life-sustaining treatment to be provided or continued.

OR

____ C. I want my life to be prolonged to the greatest extent possible without regard to my condition, the chances I have for recovery or the cost of procedures.

AND/OR

____ D. I specifically express the following desires concerning life-sustaining treatment.

_____

_____

_____

_____

_____

17. My Choices Regarding Contribution of Anatomical Gift

If either statement reflects your desires, sign the line next to the statement. You do not have to sign either statement. If you do not wish to sign either statement, your agent (if you have one) and your family will have the authority to make a gift of all or part of your body under the Uniform Anatomical Gift Act.

⑨ I **do** want to make a gift under the Uniform Anatomical Gift Act, effective upon my death, of:

⑨ Any needed organs or parts; or _____

⑨ The parts or organs listed: (Signature)

_____

_____

_____

⑨ I **do not** want to make a gift under the Uniform Anatomical Gift Act, _____ nor do I want my agent or family to (Signature) do so.

18. My Instructions Regarding Autopsy

If either statement reflects your desires, sign the line next to the statement. You **do not** *have to sign either statement. If you do not sign either statement, your agent (if you have one) and your family will be able to authorize an autopsy.*

⑨ I **do** authorize an examination of my _____ body after death to determine the (Signature) cause of my death.

⑨ I my body after death to determine the cause of my death. **do not** authorize an examination of _____(Signature)

19. Choices Regarding Disposition of my Remains

If either statement reflects your desires, sign the line beneath the statement. You do not have to sign either statement. If you do not sign either statement, your agent (if you have one) and your family will be able to direct the disposition of your remains.

⑨ I **do** authorize

_____ _____

(name) (phone)

_____

(address/city/state/zip)

to direct the disposition of my remains by the following method:

⑨ Burial

⑨ Cremation

_____

(signature)

OR

⑨ I have described the way I want my remains disposed of in:

⑨ A written contract for funeral services with:

_____ *(name and phone of mortuary/cemetery)*

_____

(address/city/state/zip)

⑨ My will.

⑨ Other:_____

_____

(signature)

By signing below, I am executing this advance directive for health care and, by so doing, am revoking any prior durable power of attorney for health care.

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

SIGNATURE: Sign and date the form here in the presence of your witnesses/notary.

_____	_____
(date)	*(signature)*
_____	_____
(address)	*(print your name)*
_____	
(city) *(state)*	

STATEMENT OF WITNESSES: I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence, (2) that the individual signed or acknowledged this advance directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

First Witness	Second Witness
_____	_____
(print name)	*(print name)*
_____	_____
(address)	*(address)*
_____	_____
(city) *(state)*	*(city)* *(state)*
_____	
_____ *(signature of witness)*	*(signature of witness)*
_____	_____
(date)	*(date)*

ADDITIONAL STATEMENT OF WITNESSES: At least one of the above witnesses must also sign the following declaration:

I further declare under penalty of perjury under the laws of California, that I am not related to the individual executing this advance health care directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law.

_____

_____ *(signature of witness)* *(signature of witness)*

SPECIAL WITNESS REQUIREMENT: The following statement is required only if you are a patient in a skilled nursing facility – a health care facility that provides the following basic services: skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. The patient advocate or ombudsman must sign the following statement:

STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN

I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section 4675 of the Probate Code.

_____	_____
(date)	*(signature)*
_____	_____
(address)	*(print your name)*
_____	
(city) *(state)*	

ACKNOWLEDGEMENT OF NOTARY PUBLIC

State of California)

County of _____)

On _____, before me, _____(here insert name and title of the officer), personally appeared _____ personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same.

WITNESS my hand and official seal.

Signature: _____ (Seal)

This document is valid only if signed by two witnesses OR acknowledged before a notary public.