MAINE 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.

HEALTH CARE DIRECTIVE AND POWER OF ATTORNEY

Under the Uniform Health Care Decisions Act *18-A*
M.R.S.A. § 5-801 et seq.

PART I. POWER OF ATTORNEY FOR HEALTH CARE

I, ________________ currently of__________________________, _____________________,
name street address city

Maine, whose birth date is ________________, execute this Health Care Directive and Power of

Attorney so that I might obtain mental health care and treatment.

(1) DESIGNATION OF AGENT: I, designate the following individual as my agent to make mental health-care decisions for me:

____ __________________________________
(name of individual) (home phone) (work phone)

____
(address)

____
(city) (state) (zip code)

(2) DESIGNATION OF ALTERNATIVE AGENT: (*OPTIONAL)* If I revoke this agent's authority or if my agent is not willing, able or reasonably available to make mental health care decisions for me, I designate as my first alternate agent:

____ __________________________________
(name of individual) (home phone) (work phone)

____
(address)

____

(city) (state) (zip code)

(3) AGENT AND ALTERNATIVE AGENT UNAVAILABLE: If I revoke the authority of my agent and first alternate agent, if I have named one, or if neither my agent or alternate, if I have named one, is willing, able or reasonably available to make health-care decisions for me, the instructions in this health care directive are nevertheless to be followed without need for the express authorization of an agent. YES____ NO_____

(4) AGENT'S AUTHORITY: My agent is authorized to make all health-care decisions, consistent with the instructions and limitations as set out in this document, that in my agent's judgment relate to psychiatric, psychological and emotional care and treatment, including the right to consent, withhold consent or withdraw consent to any test, procedure, program of medications or any form of mental health care and treatment and to select or discharge any mental health care providers or institutions.

(5) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when: (*Indicate the applicable options*)

____ my primary physician, or, if I should be in an emergency room or in a treatment setting, the attending physician determines that I am unable to make my own health-care decisions.

_____ my primary physician, or, if I should be in an emergency room or in a treatment setting, the attending physician determines that I meet involuntary hospitalization standards.

_____ my primary physician, or, if I should be in an emergency room or in a treatment setting, the attending physician determines that if I do not receive psychiatric hospitalization or the treatment as set out in this instrument my condition will quickly deteriorate such that I would soon meet the standard for involuntary hospitalization.

______ other. Describe____

____

____

The above options require a second physician's opinion. Yes._____ No _____

I waive the 2nd opinion requirement if another physician is not available. Yes _____ No ______
(If I require a second opinion and do not waive the requirement should no second physician be available, I understand that my advance directive may not become effective.)

(6) AGENT'S OBLIGATION: My agent shall make health-care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health-care decisions for me in accordance with what the 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.

(7) NOMINATION OF GUARDIAN: *(OPTIONAL)* If a guardian of my person needs to be appointed for me by a court, I nominate the following individual to be appointed as my guardian.

____ ________________________________
(name of individual) (home phone) (work phone)

____
(address)

____
(city) (state) (zip code)

PART 2 INSTRUCTIONS FOR HEALTH CARE

I request that I be provided the following treatment:

I. 24 hour care

Alternatives to hospitalization

In the event my condition becomes serious enough that I am found to need 24 hour care, I prefer to avoid hospitalization as possible, and request that the following services be explored first.

_____ Crisis respite services. I prefer to receive services at the following agencies: ________
names of agencies

____
you have preferences

____

____ In-home crisis services. I prefer to receive servies at the following agencies: __________
names of agencies
____
if you have preferences

____ Other services (describe) ____

____

My reasons for wanting these services as alternatives to hospitalization are as follows:

(optional, but recommended)____

____

____

____

Psychiatric Hospitalization

In the event that psychiatric hospitalization is the only suitable alternative, I direct that it be sought at the following hospitals in the following order of priority:

____ name of hospital

____ name of hospital

____ name of hospital

____ name of hospital

This directive may operate as my informed consent to admission as a voluntary patient to the above listed hospitals.

This consent shall operate even if I pose any verbal objections at the time. Yes_____ No _____
If none of the above hospitals have available beds, this directive may operate as my informed consent to admission to any other hospital as follows: *(Select applicable option)*

_______ To any other hospital, provided I do not object at the time.

_______ To any other hospital, even if I am objecting at the time, *except for the following listed hospitals.*

____ name of hospital to which my consent is *not* given

____ name of hospital to which my consent is *not* given

____ name of hospital to which my consent is *not* given

My reasons for wanting these psychiatric hospitalization options are as follows:

(optional, but recommended)____

____

____

____

If I need to be transported to a psychiatric hospital as an involuntary patient, I request that I be transported by the following means:

_______ Ambulance

_______ Sheriff or police vehicle. (I understand that by requesting this service I am waiving any claims or rights I may have under law to be transported in a medically equipped vehicle in the company of emergency medical technicians or other medically trained personnel.)

Other notes regarding transportation and my reasons for requesting transportation by this means are as follows: ____

____

II. Medications

I consent, and my agent is authorized to consent to the administration of medications as follows. *(select options*)

Medication	Dosage Limits, if any	Only Orally If checked
______________________	______________________	__________
______________________	______________________	__________
______________________	______________________	__________
______________________	______________________	__________

____ All medications as prescribed by my primary physician, except as may be limited below.

_____ All medications as authorized by my agent except as may be limited below.

______ I do not authorize and my agent may not consent to the following medications.

Medication: ___________________________

____

____

____

My reasons for not consenting to the above medications is as follows: (optional but

recommended) ____

____

____

______ If any action can be taken to eliminate my above stated concerns regarding the excluded medications, my agent is authorized to consent to their administration provided such additional action is taken to accommodate my stated concerns.

________ Other instructions with regard to medications: _______________________________

____

____

____

____

____

III. Emergency Interventions while in a hospital

I understand that while I am in a psychiatric facility certain interventions may be authorized in an emergency should my behavior be imminently dangerous to myself or others.

I believe such an emergency can be avoided if I am treated in the following way: _____

____

____

____

____

If an emergency nevertheless arises, I prefer emergency interventions be implemented as follows: (State preferences with regard to the use of seclusion, restraint, offer of oral medications, medications by injection.)

____

____

____

III. Other treatment while in a hospital

I have responded favorably to the following treatment in a hospital setting, and request that these treatment options be offered.

Describe treatment options (family therapy, for example) ________________________________

____

____

____

IV. Electroconvulsive Therapy (ECT)

____ I do not consent and my agent is not authorized to consent to the administration of ECT.

_____ I consent to the administration of ECT as prescribed by my primary physician, except as may be limited below.

____ I consent to the administration of ECT as authorized by my agent, except as may be limited below.

_____ Limitations upon consent to the administration of ECT:

_______ My consent is limited to _______ number of treatments.

_______ Consent may not be sought from my agent until s/he has had _____ days to consider the risks and benefits of the treatment.

_______ My consent is otherwise limited as follows: ______________________________

____

____

My reasons for consenting or refusing ECT as set out above, is as follows: (optional, but recommended)____

____

____

V. Notices

If I am admitted to a facility, I request that the following individuals be notified immediately.

_______________________________________ _______________________________
(name of individual) (home phone) (work phone)

____
(address)

____
(city) (state) (zip code)

_______________________________________ _______________________________
(name of individual) (home phone) (work phone)

____
(address)

____
(city) (state) (zip code)

VI. Child Care Arrangements If I am to be admitted to residential care or to a hospital, or I am otherwise unable to care for my children, and I have not made prior child care arrangements, I authorize my agent to make those arrangements. If my agent or alternative is not available, I request that the following individual be contacted to care for my children temporarily:

_______________________________________ _______________________________

(name of individual) (home phone) (work phone)

____
(address)

____ (city)
(state) (zip code)

VI. Other Instructions

____

____

____

____

____

PART 3 PRIMARY PHYSICIAN

I designate the following as my primary physician, for the purposes of this directive:

____ ________________________

(name of physician) (phone number)

____

(address)

____

(address)

____

(city) (state) (zip code)

A COPY OF THIS FORM HAS THE SAME EFFECT AS THE ORIGINAL.

____ Dated: ______________________________

signature

____ ____________________________________

witness signature witness signature

____ ____________________________________

witness Address witness address

____ ____________________________________

city state zip code city state zip code

Dated:____ Dated: __________________________________