NEVADA 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.

NOTICE TO PERSON MAKING AN ADVANCE DIRECTIVE FOR PSYCHIATRIC CARE

THIS IS AN IMPORTANT LEGAL DOCUMENT. IT CREATES AN ADVANCE DIRECTIVE FOR PSYCHIATRIC CARE. BEFORE SIGNING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

THIS DOCUMENT ALLOWS YOU TO MAKE DECISIONS IN ADVANCE ABOUT CERTAIN TYPES OF PSYCHIATRIC CARE. THE INSTRUCTIONS YOU INCLUDE IN THIS ADVANCE DIRECTIVE WILL BE FOLLOWED IF TWO PROVIDERS OF HEALTH CARE, ONE OF WHOM MUST BE A PHYSICIAN OR LICENSED PSYCHOLOGIST AND THE OTHER OF WHOM MUST BE A PHYSICIAN, A PHYSICIAN ASSISTANT, A LICENSED PSYCHOLOGIST, A PSYCHIATRIST OR AN ADVANCED PRACTICE REGISTERED NURSE WHO HAS THE PSYCHIATRIC TRAINING AND EXPERIENCE PRESCRIBED BY THE STATE BOARD OF NURSING PURSUANT TO **NRS 632.120**, DETERMINES THAT YOU ARE INCAPABLE OF MAKING OR COMMUNICATING TREATMENT DECISIONS. OTHERWISE YOU WILL BE CONSIDERED CAPABLE TO GIVE OR WITHHOLD CONSENT FOR THE TREATMENTS. YOUR INSTRUCTIONS MAY BE OVERRIDDEN IF YOU ARE BEING HELD IN ACCORDANCE WITH CIVIL COMMITMENT LAW. BY EXECUTING A DURABLE POWER OF ATTORNEY FOR HEALTH CARE AS SET FORTH IN **NRS 162A.700** TO **162A.865**, INCLUSIVE, YOU MAY ALSO APPOINT A PERSON AS YOUR AGENT TO MAKE TREATMENT DECISIONS FOR YOU IF YOU BECOME INCAPABLE. THIS DOCUMENT IS VALID FOR TWO YEARS FROM THE DATE YOU EXECUTE IT UNLESS YOU REVOKE IT. YOU HAVE THE RIGHT TO REVOKE THIS DOCUMENT AT ANY TIME YOU HAVE NOT BEEN DETERMINED TO BE INCAPABLE. YOU MAY NOT REVOKE THIS ADVANCE DIRECTIVE WHEN YOU ARE FOUND INCAPABLE BY TWO PROVIDERS OF HEALTH CARE, ONE OF WHOM MUST BE A PHYSICIAN OR LICENSED PSYCHOLOGIST AND THE OTHER OF WHOM MUST BE A PHYSICIAN, A PHYSICIAN ASSISTANT, A LICENSED PSYCHOLOGIST, A PSYCHIATRIST OR AN ADVANCED PRACTICE REGISTERED NURSE WHO HAS THE PSYCHIATRIC TRAINING AND EXPERIENCE PRESCRIBED BY THE STATE BOARD OF NURSING PURSUANT TO **NRS 632.120**. A REVOCATION IS EFFECTIVE WHEN IT IS COMMUNICATED TO YOUR ATTENDING PHYSICIAN OR OTHER HEALTH CARE PROVIDER. THE PHYSICIAN OR OTHER PROVIDER SHALL NOTE THE REVOCATION IN YOUR MEDICAL RECORD. TO BE VALID, THIS ADVANCE DIRECTIVE MUST BE SIGNED BY TWO QUALIFIED WITNESSES, PERSONALLY KNOWN TO YOU, WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE. IT MUST ALSO BE ACKNOWLEDGED BEFORE A NOTARY PUBLIC.

NOTICE TO PHYSICIAN OR OTHER PROVIDER OF HEALTH CARE

Under Nevada law, a person may use this advance directive to provide consent or refuse to consent to future psychiatric care if the person later becomes incapable of making or communicating those decisions. By executing a durable power of attorney for health care as set forth in **NRS 162A.700** to **162A.865**, inclusive, the person may also appoint an agent to make decisions regarding psychiatric care for the person when incapable. A person is “incapable” for the purposes of this advance directive when in the opinion of two providers of health care, one of whom must be a physician or licensed psychologist and the other of whom must be a physician, a physician assistant, a licensed psychologist, a psychiatrist or an advanced practice registered

nurse who has the psychiatric training and experience prescribed by the State Board of Nursing pursuant to **NRS 632.120**, the person currently lacks sufficient understanding or capacity to make or communicate decisions regarding psychiatric care. If a person is determined to be incapable, the person may be found capable when, in the opinion of the person's attending physician or an advanced practice registered nurse who has the psychiatric training and experience prescribed by the State Board of Nursing pursuant to **NRS 632.120** and has an established relationship with the person, the person has regained sufficient understanding or capacity to make or communicate decisions regarding psychiatric care. This document becomes effective upon its proper execution and remains valid for a period of 2 years after the date of its execution unless revoked. Upon being presented with this advance directive, the physician or other provider of health care must make it a part of the person's medical record. The physician or other provider must act in accordance with the statements expressed in the advance directive when the person is determined to be incapable, except as otherwise provided in **section 14** of this act. The physician or other provider shall promptly notify the principal and, if applicable, the agent of the principal, and document in the principal's medical record any act or omission that is not in compliance with any part of an advance directive. A physician or other provider may rely upon the authority of a signed, witnessed, dated and notarized advance directive.

ADVANCE DIRECTIVE FOR PSYCHIATRIC CARE

I,....., being an adult of sound mind or an emancipated minor, willfully and voluntarily make this advance directive for psychiatric care to be followed if it is determined by two providers of health care, one of whom must be my attending physician or a licensed psychologist and the other of whom must be a physician, a physician assistant, a licensed psychologist, a psychiatrist or an advanced practice registered nurse who has the psychiatric training and experience prescribed by the State Board of Nursing pursuant to **NRS 632.120**, that my ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that I lack the capacity to refuse or consent to psychiatric care. I understand that psychiatric care may not be administered without my express and informed consent or, if I am incapable of giving my informed consent, the express and informed consent of my legally responsible person, my agent named pursuant to a valid durable power of attorney for health care or my consent expressed in this advance directive for psychiatric care. I understand that I may become incapable of giving or withholding informed consent or refusal for psychiatric care due to the symptoms of a diagnosed mental disorder. These symptoms may include:

.....

PSYCHOACTIVE MEDICATIONS

If I become incapable of giving or withholding informed consent for psychiatric care, my instructions regarding psychoactive medications are as follows: (Place initials beside choice.)

I consent to the administration of the following medications: [.....]

.....

I do not consent to the administration of the following medications: [.....]

.....

Conditions or limitations:

….....

ADMISSION TO AND RETENTION IN FACILITY

If I become incapable of giving or withholding informed consent for psychiatric care, my instructions regarding admission to and retention in a medical facility for psychiatric care are as follows: (Place initials beside choice.)

I consent to being admitted to a medical facility for psychiatric care. [.....]

My facility preference is: .....

I do not consent to being admitted to a medical facility for psychiatric care. [.....]

This advance directive cannot, by law, provide consent to retain me in a facility beyond the specific number of days, if any, provided in this advance directive.

Conditions or limitations:

.....

ADDITIONAL INSTRUCTIONS

These instructions shall apply during the entire length of my incapacity. In case of a mental health crisis, please contact:

1. Name: .....
   Address: .....
   Home Telephone Number: .....
   Work Telephone Number: .....
   Relationship to Me: .....
2. Name: .....
   Address: .....
   Home Telephone Number: .....
   Work Telephone Number: .....
   Relationship to Me: .....
3. My physician:
   Name: .....
   Work Telephone Number: .....
4. My therapist or counselor:
   Name: .....
   Work Telephone Number: .....

The following may cause me to experience a mental health crisis:

.....

The following may help me avoid a hospitalization:

.....

I generally react to being hospitalized as follows:

.....

Staff of the hospital or crisis unit can help me by doing the following:

.....

I give permission for the following person or people to visit me:

.....

Instructions concerning any other medical interventions, such as electroconvulsive (ECT) treatment (commonly referred to as “shock treatment”):

.....

Other instructions:

.....

I have attached an additional sheet of instructions to be followed and considered part of this advance directive. [.....]

SHARING OF INFORMATION BY PROVIDERS

I understand that the information in this document may be shared by my provider of mental health care with any other provider who may serve me when necessary to provide treatment in accordance with this advance directive.

Other instructions about sharing of information:

.....

SIGNATURE OF PRINCIPAL

By signing here, I indicate that I am mentally alert and competent, fully informed as to the contents of this document, and understand the full impact of having made this advance directive for psychiatric care.

.... …….

Signature of Principal Date

AFFIRMATION OF WITNESSES

We affirm that the principal is personally known to us, that the principal signed or acknowledged the principal's signature on this advance directive for psychiatric care in our presence, that the principal appears to be of sound mind and not under duress, fraud, or undue influence, and that neither of us is:

1. A person appointed as an attorney-in-fact by this document;

2. The principal's attending physician or provider of health care or an employee of the physician or provider; or

3. The owner or operator, or employee of the owner or operator, of a medical facility in which the principal is a patient or resident.

Witnessed by:

Witness: ..... ……..

Signature Date

Witness: ..... ……..

Signature Date

STATE OF NEVADA COUNTY OF .....

CERTIFICATION OF NOTARY PUBLIC

STATE OF NEVADA COUNTY OF .....

I, ..., a Notary Public for the County cited above in the State of Nevada, hereby certify that..... appeared before me and swore or affirmed to me and to the witnesses in my presence that this instrument is an advance directive for psychiatric care and that he or she willingly and voluntarily made and executed it as his or her free act and deed for the purposes expressed in it.

I further certify that..... and....., witnesses, appeared before me and swore or affirmed that each witnessed..... sign the attached advance directive for psychiatric care believing him or her to be of sound mind and also swore that at the time each witnessed the signing, each person was: (1) not the attending physician or provider of health care, or an employee of the physician or provider, of the principal; (2) not the owner or operator, or employee of the owner or operator, of a medical facility in which the principal is a patient or resident; and (3) not a person appointed as an attorney-in-fact by the attached advance directive for psychiatric care. I further certify that I am satisfied as to the genuineness and due execution of the instrument.

This is the..... day of.....,.....

.....

Notary Public

My Commission expires: .....