SAMPLE PAD

Advance Directive of _John Doe_____ for Mental Health Care Decisionmaking.

The following is an example of the type of information you may include in your psychiatric advance directive (PAD). While this format would likely be helpful, Arkansas does not require you to use these forms to create a PAD. If you choose to write your PAD using a different format, remember you are still required to choose someone as an agent and to sign it along with two witnesses that are 18 years old or older.

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Instructions Included in My Directive
Put a checkmark in the left-hand column for each section you have completed.

_✓___ Designation of my health care agent(s).

_✓___ Authority granted to my agent.

__✓__ My preference as to a court-appointed guardian.

__✓__ My preferences about no termination in the event a guardian or other agent is appointed.

_✓___ My choice of treatment facility and preferences for alternatives to hospitalization if 24-hour care is deemed medically necessary for my safety and well-being.

__✓__ My preferences about the physicians who will treat me if I am hospitalized.

_✓___ My preferences regarding medications for psychiatric treatment.

__✓__ My preferences regarding electroconvulsive therapy (ECT or shock treatment).

__✓__ My preferences regarding emergency interventions (seclusion, restraint, medications).

____ Consent for experimental studies or drug trials.

_✓___ Who should be notified immediately of my admission to a psychiatric facility.

____ Who should be prohibited from visiting me.

_✓___ My preferences for care and temporary custody of my children.

_✓___ My preferences about revocation of my health care directive during a period of incapacity.

__✓__ Other instructions about mental health care.

__✓__ Duration of this mental health care directive.

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Advance Directive of John Doe for Mental Health Care Decisionmaking.

Part I. STATEMENT OF INTENT

Make sure you give your agent a copy of all sections of this document.

Statement of intent to Appoint an Agent:

I, John Doe, being of sound mind, authorize a health care agent to make my mental healthcare decisions when I am incompetent to make those decisions for myself. Those decisions should follow the instructions set out in this psychiatric advance directive. If I have not expressed a choice in this document, my agent has permission to make the decision that he/she determines I would make if I were able to make the decision myself.

1. Designation of Mental Health Care Agent:
A. I designate the following person as my mental healthcare agent. This person is to be notified immediately of my admission to a psychiatric facility.
Note: Make sure to list this person in Part V of your advance directive.

Name: Jane Doe

Address: 123 Main St. Little Rock, AR 72204

Day Phone: (501) 555-5555 Evening Phone: (501) 555-5556

2. Agent's Acceptance: I hereby accept this designation as mental healthcare agent.

(Agent's Printed Name) Jane Doe

(Agent's Signature) *Jane Doe*

Alternate Mental Health Care Agent
If the person named above is unavailable, unable, or unwilling to serve as my agent, I designate the following person as my mental healthcare agent. This person is to be notified immediately of my admission to a psychiatric facility.
Note: Make sure to list this person in Part V for your advance directive.

Name: Jerry Doe

Address: 456 W. Pine St. Pine Bluff, AR 71601

Day Phone: (870) 555-5555 Evening Phone: (870) 555-5556

Alternate Agent's Acceptance: I hereby accept this designation as alternate mental healthcare agent.

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(Alternate Agent's Printed Name) Jerry Doe

(Alternate Agent's Signature) Jerry Doe

3. Authority Granted to My Agent:
(Initial if you agree with statement; leave blank if you do not).
JD I retain the right to discharge or change the person named as my agent, even if I am incompetent or incapable, if allowed by law. If I discharge or replace my agent the rest of this advance directive should be followed to the best of the new decision maker's ability.

4. When Spouse is Agent and If There Has Been a Legal Separation, Annulment, or Dissolution of the Marriage (Initial if you agree with this statement, leave blank if you do not.)
_____ I desire that the person I have named as my agent, who is now my spouse, remain as my agent even if we become legally separated or our marriage is dissolved.

5. My Preference as to a Court-Appointed Guardian:
In the event a court decides to appoint a guardian who will make decisions regarding mental health treatment, I desire the following person to be appointed:

Name: Jane Doe Relationship: Sister

Address: 123 Main Street

City, State, Zip Code: Little Rock, AR 72204

Day Phone: (501) 555-5555 Evening Phone: (501) 555-5556

6. Powers of Guardian:
The appointment of a guardian of my estate or my person or any other decisionmaker shall not give the guardian or decisionmaker the power to revoke, suspend, or terminate this directive or the powers of my agent, except as specifically required by law.

Part II. FACILITY PREFERENCES

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, etc.) if you become incapacitated or unable to express your own wishes. If you want a paragraph to apply, put your initials after the paragraph letter. If you do not want the paragraph to apply to you, leave the line blank.

1. My Choice of Treatment Facility and Preference for Alternatives to Hospitalization if 24-hour Care is Medically Necessary for my Safety and Well-Being.

A. JD If my psychiatric condition is serious enough to require 24-hour care and I have no physical conditions that require immediate access to emergency medical care, I would prefer to receive this care in a program/facility that is designed as an alternative to a psychiatric hospital. I would prefer care at the programs/facilities listed below (if no preference, leave blank):

ABC Rehabilitation Center at 123 Markham St. Little Rock, AR

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B. ___JD 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:

ABC Psychiatric Hospital at 789 W. Cantrell in Little Rock, AR_____

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

Facility Name	**Reason**
DEF Psychiatric Hospital	Because the last time I was admitted there I was kept in physical restraints for the entirety of my stay and a worker there made me feel unsafe.

D. Other Information about Hospitalization:

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Part III. EMERGENCY INTERVENTION

Nothing in this section constitutes my consent to use of medication in a non-emergency situation.

A. The Following may cause me to experience a mental health crisis:

If someone touches me without asking permission or warning me that I will be touched first.

B. The Following may help me avoid a mental health crisis:

Asking me for permission to touch me or warning me that I will have to be touched.

C. Staff at the hospital or crisis center can help me by doing the following:

Talking to me before any action is taken.

D. Staff can minimize use of restraint and seclusion by doing the following:

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Explaining to me what needs to be done before any acitons are taken._____
_____
_____
_____
_____
_____
_____
_____

E. 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 are as follows. I prefer these interventions in the following order:
Fill in number, 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.

___1__ Seclusion

__5___ Physical Restraints

__6___ Seclusion and Physical Restraints (combined)

__4___ Medication by Injection

__2___ Medication in Pill Form

__3___ Liquid Medication

_____Other:_____

_____

_____

E. My Preferences About the Medical Professionals Who Will Treat Me If I Am Hospitalized

I would prefer to be treated by:

Medical Professional	**Reason**
No Preferences	

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I would prefer to not be treated by:

Medical Professional	Reason
Dr. Pill	When I was treated by this doctor I felt as though he/she didn't listen to my concerns and relied too heavily on medications to treat me.

Part IV. MEDICATION & TREATMENT INSTRUCTIONS

A. I agree to the administration of the following medication(s):

_____
_____
_____
_____
_____
_____
_____

B. I do not agree to the administration of the following medication(s):

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List the reasons why you object to the following medications.

Medication	Reason
Name of Medicine	Because when I take it, I have severe abdominal pain.

Part V. Statement of My Preferences Regarding Notification of Others, Visitors, and Custody of My Child(ren)

1. Who Should be Notified Immediately of My Admission to a Psychiatric Facility

If I am incompetent, I desire staff to notify the following individuals immediately that I have been admitted to a psychiatric facility:

Name: Jane Doe

Relationship: Sister

Address: 123 Main St. Little Rock, AR 72204

Phone (Day): (501) 555-5555

Phone (Eve): (501) 555-5556

It is also my desire that this person be permitted to visit me: Yes ✓ No

Name: Cookie Doe

Relationship: Aunt

Address: 456 Main St. Little Rock, AR 72204

Phone (Day): (501) 444-4444

Phone (Eve): (501) 444-4445

It is also my desire that this person be permitted to visit me: Yes ✓ No

Name: Jerry Doe

Relationship: Brother

Address: 456 Pine St. Pine Bluff, AR 71601

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Phone (Day): _(870) 555-5555_____

Phone (Eve): _(870) 555-5556_____

It is also my desire that this person be permitted to visit me: Yes_✓___ No_____

Name: _____

Relationship: _____

Address: _____

_____

_____

Phone (Day): _____

Phone (Eve): _____

It is also my desire that this person be permitted to visit me: Yes_____ No_____

2. Who Should be Prohibited from Visiting Me

_____

_____

_____

_____

_____

_____

_____

3. My Preferences for Care & Temporary Custody of My Children

In the event that I am unable to care for my child(ren), I want the following person as my first choice to care for and have temporary custody of my child(ren):

Name: __Cookie Doe_____ Relationship: _Aunt_____

Address: _456 Main Street_____

City, State, Zip: _Little Rock, AR 72204_____

Phone number: (Day) _(501) 444-4444_____ (Evening) _(501) 444-4445_____

In the event that the person named above is unable to care for and have temporary custody of my child(ren), I desire one of the following people to serve in that capacity.

My Second Choice

Name:_Amy Doe_____

Relationship:_Cousin_____

Address:_222 Main St. Little Rock, AR 72204____

_____

Phone (Day): (501) 888-8888_____

Phone: (Eve): _(501) 888-8889_____

My Third Choice

Name: _____

Relationship: _____

Address:_____

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Phone (Day): _____

_____

Phone: (Eve): _____

PART VI. STATEMENT OF MY PREFERENCES REGARDING REVOCATION OR TERMINATION OF THIS ADVANCE DIRECTIVE/DURABLE POWER OF ATTORNEY

1. Revocation of My Psychiatric Advance Directive

_____ My wish is that this mental health directive may be revoked, suspended or terminated by me at any time, if state law so permits.

2. Revocation of my Psychiatric Advance Directive During a Period of Incapacity

__✓___ My wish is that this mental health care directive may be revoked, suspended or terminated by me only at times that I have the capacity and competence to do so. I understand that I may be choosing to give up the right to change my mind at any time. I expressly give up this right to ensure compliance with my advance directive. My decision not to be able to change this advance directive while I am incompetent or incapacitated is made to ensure that my previous, carefully considered thoughts about how I want to be treated will remain in effect during the time I am incompetent or incapacitated.

2A. __✓___ Notwithstanding the above, it is my wish that my agent or other decisionmaker specifically ask me about my preferences before making a decision regarding mental health care, and take the preferences I express here into account when making such a decision, even while I am incompetent or incapacitated.

3. Other Instructions About Mental Health Care

(Use this space to add any other instructions that you wish to have followed. For example, information about how your bills should be paid or who should take care of your pet in your absence. If you need to, add pages, numbering them as part of this section.)

_My cable bill arrives on the 12th of each month, my electricity bill and water bill are ach due on the 4th of each month, and my gas bill is due on the 10th. I would like for my agent to see to it__ that these bills are paid from my account in a timely manner. Additionally, I have hydrangeas__ that require frequentw watering and my dog, Snoopy, needs to be walked and fed twice a day.__

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4. Duration of Mental Health Care Directive

Initial A or B.

A. _____ It is my intention that this advance directive will remain in effect for an indefinite period of time.
OR

B. _JD____ It Is my intention that this advance directive will expire two years from the date it was executed.

If my choice above is not valid under state law, then it is my intention that this advance directive remain in effect for as long as the law permits.

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PART VII. SIGNATURE PAGE

By signing here I indicate that I understand the purpose and effect of this document.

_*John Doe*_____ Date_4/8/2011_____

The directive above was signed and declared by the "Declarant," _John Doe_____ to be his/her mental health care advance directive, in our presence who, at his/her request, have signed names below as witness. We declare that, at the time of the execution of this instrument the Declarant, according to our best knowledge and belief, was of sound mind and under no constraint or undue influence. We further declare that none of us is 1) a physician; 2) the Declarant's physician or an employee of the Declarant's physician; 3) an employee of any residential health care facility in which the Declarant is a patient; 4) designated as agent or alternate under this document ; or 5) a beneficiary or creditor of the estate of the Declarant.

Dated at Pulaski County, Arkansas_____
(county, state),
this _8th_____ day of _April_____, 2011_____.

Witness 1

Signature: _*Bert Doe*_____

Printed Name: Bert Doe_____

Date: 4/8/2011_____

Address: _789 Main St. Little Rock, AR 72204____

Witness 2

Signature: _*Ernie Doe*_____

Printed Name: _Ernie Doe_____

Date: _4/8/2011_____

Address: _9101 Main St. Little Rock, AR 72204___