HEALTH CARE POWER OF ATTORNEY

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

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

Maine, whose birth date is ________________, execute this Health Care 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 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 option(s) 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 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)

(8) 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)

(9) DESIGNATION OF PRIMARY PHYSICIAN I designate the following as my primary physician, for the purposes of this directive:

____ _______________________
(name of physician) (phone number)

____
(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: ______________________________