

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.)

_____ In-home crisis services. I prefer to receive services 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.

signature Dated: _____

witness signature witness signature

witness Address witness address

city state zip code city state zip code

Dated: _____ Dated: _____

