OPTIONAL Advance Directive for Mental Health Treatment

I, _____, being a person with capacity to make mental health treatment decisions, willfully and voluntarily make known my wishes about mental health treatment by my instructions to others through this advance directive for mental health treatment, or by my appointment of an agent, or both, as authorized by the New Mexico Mental Health Treatment Decisions Act. I understand this advance directive becomes effective when one qualified mental health professional and one mental health treatment provider determine that I lack the capacity to make my own mental health treatment decisions.

I understand that I may revoke this directive in whole or in part if I am a person with capacity. I understand that I cannot revoke this directive if it is determined that I do not have capacity unless I successfully challenge that determination.

I understand there some instances where my provider may not have to follow my directives, specifically, if the treatment I directed is infeasible or unavailable, the facility or provider is not licensed or authorized to provide the treatment requested or the directive conflicts with other applicable laws.

I understand that if I have completed both a declaration and have appointed an agent and if there is a conflict between my agent's decision and my declaration, my declaration shall be followed unless I indicate otherwise.

INSTRUCTIONS FOR MENTAL HEALTH TREATMENT

If it has been determined that I lack the capacity to make my own mental health care treatment decisions and that mental health treatment is necessary, I direct that I be provided the mental health treatment I have indicated below by my signature. I understand that "mental health treatment" means services provided to prevent or reduce the symptoms of or aid in the recovery from mental illness or emotional disturbance, including but not limited to electroconvulsive treatment, treatment with medication, counseling, rehabilitation services, or evaluation for admission to a facility for care or treatment of persons with mental illness, if required.

I. My instructions about treatment, facilities and physicians

I would like the Physician(s) named below to be involved in my treatment decisions:

Dr. Contact Information

Dr. Contact Information

I do not wish to be treated by Dr.

Other Instructions:

II. My instructions about other health care providers

I am receiving care from other providers who have an impact on my mental health care. I would like the following treatment provider(s) to be contacted when this directive is effective:

Name/Profession: _____

Contact Information: _____

Name/Profession: _____

Contact Information:

III. My instructions about medications for mental health treatment

I consent, and authorize my agent to consent, to the following medications:

_____

I do **not** consent, and I do **not** authorize my agent to consent, to the administration of the following medications: _____

I have allergies to, or severe side effects from, the following: _____

Other instructions about medications: _____

IV. My Instructions about alternatives to hospitalization and hospitalization

The following may help me avoid a hospitalization:

_____

_____

If hospitalization is recommended I wish to be treated at: _____

I generally react to being hospitalized as follows:

_____

V. My Instructions about the use of seclusion or restraint

If a mental health treatment provider is considering whether or not to use seclusion or restraint on me, I would like the following to be tried before the use of seclusion or restraint is considered (circle choices):

“Talk me down": one-on-one, more medication, time out/privacy, show of authority/force, shift my attention to something else, set firm limits on my behavior, help me to discuss/vent feelings, decrease stimulation, offer to have neutral person settle dispute, other- (specify):

_____

VI. My instructions about electroconvulsive therapy (ECT)

I do not consent, nor authorize my agent to consent to ECT.

_____ (Signature)

I consent and authorize my agent to consent to ECT.

_____ (Signature)

I consent, and authorize my agent to consent, to ECT **only** under the following conditions:

_____;

_____(Signature)

VII. Instructions about visitors

If I have been admitted to a mental health treatment facility, the following people may visit me there.

Name:

Name:

Name:

VIII. Additional instructions:

Other instructions about my mental health care:

I direct the following concerning the care of my minor children:

I direct the following concerning the care of my residence:

I direct the following concerning the care of my pets:

APPOINTMENT OF AGENT

Should it be determined that I lack capacity to make mental health treatment decisions, I direct my health care professionals to follow the instructions of my agent. I appoint:

N a m e :

_____

Address/Telephone_____

to make decisions regarding my mental health treatment.

(Optional)If the person named above refuses or is unable to act on my behalf, or if I revoke that person's authority to act as my agent, I authorize the following person to act as my agent in the alternative:

Name:

Address/Telephone:

My agent is authorized to make decisions that are consistent with the wishes I have expressed in my declaration. If my wishes are not expressed, my agent is to act in what he or she believes is in my best interest.

ACCEPTANCE OF APPOINTMENT

I accept this appointment and agree to serve as the agent to make mental health treatment decisions for _____ while he/she does not have capacity to make mental health treatment decisions and that I have a duty to make decisions consistent with the desires expressed in this appointment. _____(signature)

(Optional) I accept this appointment as an *alternate* and agree to serve as the agent to make mental health treatment decisions for _____ while he/she does not have capacity to make mental health treatment decisions and that I have a duty to make decisions consistent with the desires expressed in this appointment.
_____(signature)

SIGNATURE AND WITNESS

I understand the importance of the advance directive for mental health treatment and am emotionally and mentally competent to make this advance directive.
Signed this _____ day of _____, 20___

_____
Signature
County, City and State of Residence _____
This advance directive was signed in my presence:

_____
Signature of Witness

_____
Address of Witness

Notary Block (OPTIONAL)

State of New Mexico }
ss}
County of _____ }

SUBSCRIBED AND SWORN TO before me on this ____ day of _____ , 20___ by _____.

_____ my commission expires: _____
Notary Public

I have given copies of this Advance Directive for Mental Health Treatment to:

Name_____Telephone_____
Name_____Telephone_____
Name_____Telephone_____