MINNESOTA ADVANCE PSYCHIATRIC AND HEALTH CARE DIRECTIVE

To My Doctors, Health Care Providers, Family and Friends:

I, _____, am a competent adult. I willfully and voluntarily make the following health care instructions, to be followed if I become incapable of making sound decisions about my health care.

I understand that I have the right to make medical, mental health, and other health care decisions for myself as long as I am capable of doing so. I understand that I have the right to revoke this document or any part of it at any time as long as I am mentally capable of doing so.

I understand that any agent or proxy appointed by me is under no legal duty to act. However, those persons appointed by me have agreed to act as my agent or proxy. It is my intention that anyone appointed by me must act consistent with my instructions as stated in this document and any wishes as otherwise made known by me.

By signing this document, I am revoking any previous advance directive or health care power of attorney that I have made.

I. INSTRUCTIONS ABOUT MY MENTAL HEALTH CARE

A. My Beliefs, Concerns and Preferences about my mental health care.

I am telling you what my beliefs, preferences and concerns are about my mental health problems and my care. I am giving you this information because I want my choices to be honored, and I want you to help me have as much control over my life as possible while I work on my recovery and managing my illness.

1. The following thoughts, feelings and wishes (including religious or philosophical beliefs, traditions, personal history, values, or other beliefs) are especially important for those involved in my care to know about me:

_____
_____
_____
_____
_____

2. My mental health problems affect me in the following ways: (Describe the mental health problems that impair or disable you. You may include diagnoses.)

_____
_____
_____
_____
_____

3. My capacity to make sound decisions about my care may be impaired when I have the following symptoms and behaviors. (You may also describe at what point you want crisis services contacted or to go to the hospital.)

_____
_____
_____
_____
_____

4. The following things help me to relax and to feel better when I am having a difficult time:

- ☐ Participating in groups
- ☐ Having a particular person visit: _____ (name)
- ☐ Quiet time by myself
- ☐ Talking to staff
- ☐ Talking to other patients
- ☐ Talking to a particular person: _____ (name)
- ☐ Listening to music
- ☐ Exercise or taking a walk
- ☐ Calling my therapist
- ☐ Taking a bath or shower
- ☐ Taking a nap
- ☐ Other: Please list

_____
_____
_____
_____
_____

5. The following things make it more difficult for me to calm down when I am upset or not doing well:

- ☐ Being made to disrobe/put on a gown
- ☐ Being touched
- ☐ Loud noises
- ☐ Being isolated
- ☐ People in uniform
- ☐ Being put in seclusion
- ☐ Having a particular person visit: _____ (name)
- ☐ Being ignored or put off when I make a request for help
- ☐ Having other patients who I do not know try to talk to me
- ☐ Not being allowed to smoke
- ☐ Sharing a room
- ☐ Having to participate in groups
- ☐ Other: Please list

_____
_____
_____
_____
_____

6. I have the following preference regarding gender of staff:

- ☐ women staff
- ☐ men staff
- ☐ no preference

B. TREATMENT WITH MEDICATIONS

1. The following medications may **not** be given to me:

Medication	**Reason it may not be given, including problems and risks:**
a._____	_____
	_____
b._____	_____
	_____
c._____	_____
	_____

If others, please attach additional sheet, and check this box. ☐

2. The following medications **may be given** to me:

Medication	**Dosage**	**When it may be given to me**
a._____	_____	_____
b._____	_____	_____
c._____	_____	_____

If others, please attach additional sheet, and check this box. ☐

3. If a new medication is being proposed for me, my proxy/agent may act according to the following instructions to him/her:

☐ You shall not agree to the use of any new medication.
☐ You shall not agree to the use of a new neuroleptic medication.
☐ You may agree to a trial period of a new neuroleptic medication, but should stop if I get the following symptoms:

_____
_____

☐ You may agree to a trial period of a new anti-depressant or anti-anxiety medication, but should stop if I get the following symptoms:

_____
_____

☐ I will leave it up to your informed judgment on whether to try any new medications after you consult with my doctors about the possible risks and benefits.

C. ECT (ELECTRO-CONVULSIVE THERAPY) TREATMENT:

☐ I do not consent to the use of ECT.
☐ I consent to the use of ECT, with the following conditions or limits:

_____
_____
_____

☐ I will leave it up to my proxy/agent to make this decision after consulting with my doctors about the possible risks and benefits of this procedure.

D. OTHER MENTAL HEALTH TREATMENT

1. My preferences about my need for crisis intervention and hospitalization: (Check those that apply.)

☐ I would prefer that a crisis-stabilization alternative to inpatient hospitalization be tried first.

a. name of program _____ phone # _____
contact person _____ phone # _____
b. name of program _____ phone # _____
contact person _____ phone # _____
c. please find a program for me if none is listed.

☐ If hospitalization is necessary, I would prefer to be hospitalized here:

a. name of hospital _____

b. name of hospital _____

☐ I **do not** want to be hospitalized at the following hospitals:

a. name of hospital _____
reason _____
_____

b. name of hospital _____
reason _____
_____

2. My preferences about the doctors and nurses treating me:

☐ My choice of treating doctors is:

a. name _____ phone # _____

b. name _____ phone # _____

☐ I would like the treating doctor to consult with the following mental health professionals who help me in the community:

a. name _____ phone # _____

occupation _____

b. name _____ phone # _____

occupation _____

c. name _____ phone # _____

occupation _____

☐ I **do not** want to be treated by the following doctors:

a. name _____

b. name _____

c. name _____

☐ I **do not** want to be under the care of the following nurses or other health care practitioners:

a. name _____

b. name _____

c. name _____

3. My instructions about notification and visitors:

☐ **Notification of others.** If I am hospitalized, I give permission for the following persons to be immediately notified, and to be given information about my condition and care:

a. name _____ phone #(h)_____
relationship_____ (w)_____

b. name _____ phone # (h)_____
relationship_____ (w)_____

☐ **Visits** by the above persons are permitted, unless otherwise stated here:
_____
_____
_____

☐ I **do not** want the following people to visit me:

a. name _____ relationship _____

b. name _____ relationship _____

4. Other mental health instructions:

a. Emergency measures. If I am becoming dangerous to myself or another person, I prefer that you use the following interventions:

☐ Seclusion alone
☐ Restraint alone
☐ Both seclusion and restraint
☐ Oral medication
☐ Injection of medication
name: _____

b. I have a particular objection to some of the above interventions:

1. Intervention: _____
reason: _____
_____
_____

2. Intervention: _____
reason: _____
_____
_____

c. Exercise that is helpful to me:
_____
_____
_____

d. I can benefit by the following use of talk therapy:
_____
_____
_____

e. Other care or treatment that helps:
_____
_____
_____

f. Other care or treatment that should **not** be part of my treatment:
_____
_____
_____

II. APPOINTMENT OF A MENTAL HEALTH PROXY/AGENT (OPTIONAL BUT RECOMMENDED)

I appoint the following person(s) to act as my proxy/agent to make decisions about neuroleptics or ECT and my other mental health care needs. Decisions must be made according to my instructions and preferences. I know I can revoke this appointment or appoint a new proxy/agent at any time as long as I have the capacity to do so. **The person(s) may be the same person(s) as my general health care agent(s), but does not have to be.** These person(s) have consented to act as my mental health proxy/agent:

a. Designated proxy/agent:
name _____
relationship: _____
address: _____
_____
telephone: (home) _____
(cell/work)_____

b. Alternate proxy/agent:
name _____
relationship: _____
address: _____
_____
telephone: (home) _____
(cell/work) _____

III. INSTRUCTIONS ABOUT MY OTHER HEALTH CARE

A. GENERAL INSTRUCTIONS AND PREFERENCES:

1. My spiritual, religious, or philosophical beliefs about my health care that you should be aware of are:

_____
_____
_____
_____
_____

2. My health care goals are:

_____
_____
_____
_____
_____

3. My health problems, including other, non-mental health related diagnoses are:

_____
_____
_____
_____
_____

4. Particular concerns about how my health might affect my family are:

_____
_____
_____
_____
_____

5. (For women of child-bearing age) My preferences about how my care should be handled if I am pregnant are:

_____
_____
_____
_____

6. If I were completely dependent on others for my care and unable to speak for myself, I would want them to know these things:

_____
_____
_____
_____
_____

7. This is how I feel about being admitted to a nursing home or other community residential facility:

_____
_____
_____
_____
_____

8. These are my instructions about pain relief and other medications:

_____
_____
_____
_____
_____

9. These are some other instructions about my general health care that you should follow if I am admitted to a hospital or other care facility:

_____
_____
_____
_____
_____

10. **I have/have not** (circle one) completed a **Designated Standby Custodia**n form to apply in the event I am hospitalized or otherwise am temporarily unable to provide care for my child/ren, which is attached to this document. **(Important Note: The designated standby custodian form must be renewed every year.)** I also have the following instructions about the care of my child/ren:

_____
_____
_____
_____

11. These are some instructions about my home, pets or other things that need to be taken care of if I am admitted to a hospital or other care setting:

_____
_____
_____
_____

12. I want these persons to be contacted if I am hospitalized and incapacitated, and to be given information about my condition:

a. name _____ phone# (h)_____
relationship: _____ (w/c) _____

b. name _____ phone# (h)_____
relationship: _____ (w/c) _____

B. INSTRUCTIONS ABOUT PROVIDERS OF CARE AND TREATMENT

☐ I would like to receive care for my physical health needs at the following hospital(s):

a. name: _____

b. name: _____

☐ I would like to be under the care of the following doctor(s):

a. name: _____ phone # _____

b. name: _____ phone # _____

☐ I **do not** want the following hospitals/doctors to care for me:

a. name: _____

b. name: _____

C. END-OF-LIFE INSTRUCTIONS AND EXPLANATION OF PREFERENCES

1. End of life definition: Although I greatly value life, I also believe that at some point treatment other than comfort care (pain relief) will not contribute to my well-being and may be stopped. For me, that point is the following:

☐ When two (2) doctors have examined me and determined that: 1) I am in a terminal state, including a persistent vegetative state, and life support would only delay the moment of death; or 2) I have an irreversible condition, including a coma, from which there is no reasonable hope of recovery.

OR

☐ My own decision about when I have reached that point, or other conditions under which I do or do not wish to be kept alive are:

_____

2. Where I would like to die:

3. Other wishes about dying:

   a. My wishes about burial/cremation:

   b. My wishes about organ donation:

   c. Other:

4. My wishes about specific end-of-life treatments:

   a. Cardio-pulmonary resuscitation ("Do not resuscitate—DNR" orders):

I **do/ do not (circle one)** have a doctor's order regarding resuscitation. (This can be a POLST --Physician's Order for Life Sustaining Treatment-- or some other form of a

doctor's order signed by your physician. These are generally used if you have a condition that is likely terminal. If you have an order, please attach it.)

b. Being put on a respirator:

_____
_____
_____
_____
_____

c. Dialysis (kidney machine)/major blood transfusions:

_____
_____
_____
_____
_____

d. Artificial nutrition and hydration ("feeding tube"):

_____
_____
_____
_____
_____

e. Other (including invasive tests, major surgery, chemotherapy etc.):

_____
_____
_____
_____
_____

IV. APPOINTMENT OF PROXY/AGENT (OPTIONAL, BUT RECOMMENDED)

A. I hereby appoint my proxy/agent and grant him/her the following powers to make health care decisions for me in the event I lack the capacity to decide or speak for myself. I have discussed my health care directive with my proxy/agent(s) who has consented to act as my proxy/agent(s). I understand that I can appoint joint proxy/agent(s) or name an alternative agent. **I also understand that I may appoint the same person(s) as my proxy/agent(s) for my mental health care.**

Name _____
Relationship: _____
Address: _____
_____
Phone: (h) _____
(w) _____

check one: ☐ sole agent ☐ joint agent ☐ alternate

Name _____
Relationship: _____
Address: _____
_____
Phone: (h) _____
(w) _____

check one: ☐ joint agent ☐ alternate

If joint agents, can one of them act independently if necessary? ☐yes ☐no

B. POWERS OF MY PROXY/AGENT(S)

I authorize my proxy/agent(s) to do the following:

1. Make any health care decisions for me, including the power to give, refuse, or withdraw consent to my care, treatment or procedure, including stopping or starting care that might keep me alive. I have decided to limit this power as follows: (If no limits, check here. ☐)

_____
_____
_____

2. Choose my health care providers. I have decided to limit this power as follows: (If no limits, check here. ☐)

_____
_____
_____

3. Choose where I live and what care and services I receive. I have decided to limit this power as follows: (If no limits, check here. ☐)

_____
_____
_____

4. Review my medical records and release them to others. I have decided to limit this power as follows: (If no limits, check here. ☐)

_____
_____
_____

C. OPTIONAL POWERS

I authorize my proxy to do the following, which I understand are completely optional on my part:

☐ Decide where to donate my organs, according to my previous instructions.

☐ Decide what will happen to my body, according to my previous instructions.

☐ Make health care decisions for me even though I still have the capacity to do so myself. I have decided to limit this Power as follows: (If no limits, check here.☐)

_____
_____
_____
_____
_____

V. AUTHORIZATION TO RELEASE INFORMATION

A. I direct that my proxy/agent have the same right as I would to receive, review, and obtain copies of my medical records and to consent to disclosure of these records, with limitations as follows: (If none, check here. ☐)

_____
_____
_____
_____

B. In the event that I am hospitalized and have not named a proxy/agent, I authorize the release of the following health, mental health and/or social service records to the hospital which I am in, with limitations as follows: (If none, check here. ☐)

a._____
b._____
c._____
d._____

This also includes conversations between the hospital and the above providers, with limitations as follows: (If none, check here. ☐)

_____
_____
_____
_____

C. If I am hospitalized, I request and authorize the hospital to notify the following persons, and to give them information and answer their questions about my care and treatment, with limitations as follows: (If none, check here. ☐)

_____
_____
_____
_____

This authorization specifically includes re-release of all documents in my records obtained from any other sources, specifically including the re-release of any chemical dependency records which may be included, and is valid as long as this directive is in effect.

V. NOMINATION OF GUARDIAN OR CONSERVATOR (OPTIONAL)

My proxy/agent, (Name) _____ is/is not (circle one) nominated to be my guardian or conservator in the event a guardianship petition is filed.

If my proxy or agent is not nominated, I nominate the following person (this is optional):

Name _____
Address _____
Telephone(s) _____
Relationship (if any) _____

VI. GENERAL POWER OF ATTORNEY (optional)

I have/have not (circle one) completed a General Power of Attorney document to apply in the event I am hospitalized or otherwise mentally incapable to handle my financial affairs. That document is attached, or can be found in the following place:

_____
_____

VII. DISTRIBUTION OF DOCUMENT

I have given a copy of this directive to the following people, and give them permission to release this document to my mental and physical health care providers for the purpose of affording me appropriate treatment according to my instructions. I am including their telephone contact information:

_____
_____
_____
_____
_____
_____
_____

This document, including all attached pages and the signature pages, consists of ___ pages. **Date and initial each page at the time you sign this document.**

VIII. SIGNING OF DOCUMENT

Sign and date here in the presence of two witnesses, neither of whom should be your proxy, agent or nominee for guardianship. You may sign in front of a notary only if you are filling out the Health Care Directive portion, but not the Mental Health portion.

I sign my name to this document on _____, _____. I am thinking clearly and competently, I agree with everything written in this document and I have made these instructions willingly.

_____
MY SIGNATURE
ADDRESS _____
_____
PHONE _____
Date of Birth _____
(Optional, but helpful.)

WITNESSES:
I certify that I am at least eighteen (18) years of age and that in my presence on the date appearing above the principal signed or acknowledged the signing of this document. It is my belief that the principal fully understands the nature and significance of the declarations made herein. I am not named as proxy, agent or alternative in the document. If I am a health care provider, or an employee of a health care provider providing direct care to the principal on or before the date appearing above, I have so noted below.

_____	_____
WITNESS SIGNATURE	WITNESS SIGNATURE
Address _____	Address _____
Telephone _____	Telephone _____
Health Care Provider? ☐ Yes ☐ No	Health Care Provider? ☐ Yes ☐ No
_____	_____
DATE	DATE

OR: NOTARIZATION, acceptable if only the health care portion but not the mental health portion is filled out:

STATE OF MINNESOTA
COUNTY OF _____

The foregoing document was signed or acknowledged before me this ____ day of _____, _____, by the principal therein. I am not the proxy, agent or alternative in the foregoing document.

_____
Notary Public

Designated Standby Custodian
(Minnesota Statutes Chapter 257B)

A. I, _____, appoint _____,
(Please print name and relationship to children) (Please print name of Designated Parent)

_____
(address and telephone number)

as the standby custodian for: _____
(Child/ren's names, **please print**)

to take effect upon the occurrence of the following triggering event(s): _____
_____
_____
_____
_____.

If I have indicated more than one triggering event, it is my intent that the triggering event which occurs first shall take precedence. If I have indicated "my death" as the triggering event, it is my intent that the person named in the designation to be standby custodian for my child(ren) in the event of my death shall be appointed as guardian of my child(ren) under Minnesota Statutes, section 525.551, upon my death.

B. _____ is the other parent. His/her address and
(Name of Other Parent)
telephone number are: _____.

Here is additional information about the other parent. (Check all that apply):

____ The other parent died on _____.
(date of death)

____ The other parent's parental rights were terminated on _____.
(date of termination)

____ The other parent's whereabouts are unknown. (I understand that all living parents whose rights have not been terminated must be given notice of this designation pursuant to the Minnesota Rules of Civil Procedure or a petition to approve this designation may not be granted by the court.)

____ The other parent is unwilling and unable to make and carry out day-to-day child-care decisions concerning the child(ren).

____ The other parent consents to this designation and has signed this form below.

C. By this designation I am granting _____
(Name of Standby Custodian)
the authority to act for 60 days following the occurrence of the triggering event as a co-custodian with me, or in the event of my death, as custodian of my child(ren).

____ **Alternate:** (Optional) I hereby nominate _____,
(Name of Alternate Standby Custodian)

_____
(Address and Telephone Number of Alternate Standby Custodian)

as the alternate standby custodian to assume the duties of the standby custodian named above if the standby custodian is unable or unwilling to act as a standby custodian.

It is my intention to retain full parental rights to the extent consistent with my condition and to retain the authority to revoke the appointment of a standby custodian if I so choose.

D. This designation is made after careful reflection, while I am of sound mind.

_____ _____
(Date) (Designator's Signature)

_____ _____
(Witness' Signature) (Witnesses' Signature)

_____ _____
(Number and Street) Number and Street)

_____ _____
(City, State, and Zip Code) (City, State, and Zip Code)

IF APPLICABLE: I, _____,
(Name of Other Parent)

hereby consent to this designation.

_____ _____
(Date) (Signature of Other Parent)

_____
(Address of Other Parent)

I, _____ hereby accept my nomination as standby
(Name of Standby Custodian)

custodian of _____.
(Child(ren)'s Name(s))

I understand that my rights and responsibilities toward the child(ren) named above will become effective upon the occurrence of the above-stated triggering event or events. I further understand that in order to continue caring for the child(ren), I must file a petition with the court within 60 days of the occurrence of the triggering event.

_____ _____
(Date) (Signature of Standby Custodian)