# PSYCHIATRIC ADVANCE DIRECTIVE

## Wyoming

TO MY FAMILY, MY PHYSICIAN, MY LAWYER
AND ALL OTHERS WHOM IT MAY CONCERN

Declaration made this ____ day of, _____ 20 _____.

I, _____ [name] being of sound mind, willfully and voluntarily make known my desires for mental health treatment(s) to be followed should it be determined by two mental health professionals, one of whom is my attending physician, that my ability to receive and evaluate information effectively or communicate decision is impaired to such an extent that I lack the capacity to refuse or consent to mental health treatment. I understand that any treatment(s) would be toward the goal of psychiatric re-stabilization as a way of restoring my capacity and optimal mental health functioning. I further understand that psychiatric re-stabilization may include administration of prescribed liquid medication by mouth or injection, administration of prescribed medication orally, physical restrain, seclusion or crisis psychiatric counseling and that in the statements below I may give or refuse consent to any of these or other treatment options to which I stipulate.

This directive is consistent with Wyoming State Statute 35-22-301 through 308 and the Rules and Regulations for Psychiatric Advance Directives as specified by the Wyoming Department of Health.

### *DIRECTIVE DURATION AND REVOCATION UNDERSTANDINGS*

I understand this declaration expires two years after it becomes effective, unless extended by me in writing. I understand that I may revoke this declaration at any time unless I have been declared to lack capacity to give or withhold treatment by two physicians, one of whom is my attending physician.

### *UNDERSTANDING ABOUT WHEN OR WHY THIS DIRECTIVE MAY BE PUT INTO EFFECT*

I understand that I may become incapable of giving or withholding informed consent for mental health treatment due to symptoms of a diagnosed mental disorder. The symptoms may include the following:

_____

_____

_____

_____

*MY DECLARATIONS ABOUT MEDICATIONS for PSYCHIATRIC TREATMENT*

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding medications are as follows:

_____ I consent to the administration of medications.

_____ I consent to the administration of the following medications:

_____

_____

_____ I do not give consent to the administration of medications.

_____ I do not give consent to the administration of the following medications:

_____

_____

Conditions or limitations:

_____

_____

_____

*MY DECLARATIONS ABOUT PHYSICAL RESTRAINTS, SECLUSION, AND CRISIS INTERVENTIONS*

Should I become incapable of giving or withholding informed consent for mental health treatment due to the symptoms of a diagnosed mental disorder and my behaviors become dangerous to myself or others, or should I become incapable of providing for my basic need, I give consent for the following safety measures or treatment(s):

_____ Physical Restraint _____ Seclusion _____ Crisis Psychiatric Counseling

Other Interventions I prefer/conditions/limitations/concerns:

_____

_____

_____

I would NOT give consent for:

_____Physical Restraint _____ Seclusion _____ Crisis Psychiatric Counseling

Why or why not or concerns:

_____

_____

_____

*NAME OF TREATMENT PROVIDERS WITH WHOM I AM NOW OR HAVE RECENTLY BEEN INVOLVED*

Name, address and telephone number of mental health provider

Name, address and telephone number of primary mental health professional or psychiatrist

Name, address, and telephone number of attending physician

*TREATMENT FACILITY PREFERENCES*

I prefer the following facilities to be used for emergency or stabilization purposes:

_____

_____

_____

*NOTIFICATION PREFERENCES*

I would like the following persons notified if it is deemed necessary to put this directive into effect: (Names and phone numbers):

_____

_____

_____

I specifically request the following persons/entities not be notified:

_____

_____

*VISITOR PREFERENCES*

I prefer to have the following persons be allowed to visit me during a time of re-stabilization:

_____

_____

_____

I specifically request the following persons NOT be allowed to visit me during a time of re-stabilization:

_____

_____

_____

*CHILD CARE PREFERENCES*

I request the following persons be considered in arranging child care necessary during times of re-stabilization:

_____

_____

I specifically request the following persons NOT be used for child care for my children:

_____

_____

_____

*PROPERTY AND/OR PET CARE PREFERENCES*

I request the following persons be considered in arranging for the care of my property or pets during times of re-stabilization:

_____

_____

_____

I specifically request the following persons not be considered in arranging for the care of my property or pets:

_____

_____

_____

*OTHER DECLARATIONS OR PREFERENCES FOR MY RE-STABILIZATION:*

_____

_____

_____

*MENTAL HEALTH PROFESSIONAL STATEMENT REGARDING CAPACITY*

It is my professional opinion at this time that this person has the capacity to make this directive:

_____ Yes _____ No

_____ _____

Signature of Psychiatrist/Mental Health Professional Date

_____ _____

Printed Name Phone Number

*INTENTIONALLY LEFT BLANK*

## *APPOINTMENT OF AN AGENT FOR MENTAL HEALTH CARE AND TREATMENT*

_____ (check and initial) I do not want an agent acting on my behalf.

or

_____ (check and initial) I do want an agent acting on my behalf.

Should I become incapable of giving or withholding informed consent for mental health treatment due to the symptoms of a diagnosed mental disorder I hereby appoint the following named person to act as my agent in making decision regarding my mental health treatment. I understand that this person will gain this appointment only if I am declared to lack capacity by two mental health professionals, one of who is my immediate physician, or by a court of law. My agent is authorized to make decision consistent with the wishes I have expressed in this declaration, or, if not expressed, as are otherwise known to my agent. If my wishes are not expressed and are not otherwise known by my agent, that person is to act in what he or she believes to be in my best interest.

Name_____

Address_____

Telephone Number(s)_____

## *ACCEPTANCE OF APPOINTMENT AS AGENT*

I accept this appointment and agree to serve as the agent to make decisions about mental health treatment for _____. I understand I have a duty to act consistent with the desires of this individual as expressed in this appointment. I understand this document gives me the authority to make decisions about mental health treatment only while this person is incapable as determined by a court or two mental healthcare professionals, one of which is this individual's physician. I understand that he/she may revoke this declaration in whole or in part at any time and in any manner when he or she has capacity to make decisions. I also understand that I have the right to remove myself as an agent and may do so by informing this individual and/or their attending physician or primary mental health professional.

_____ _____

Signed Date

*GENERAL INFORMATION*

Please complete the following information to assist your physician and other psychiatric personnel to rapidly identify you as the person who has written this Psychiatric Advance Directive:

Name _____

Also known as _____

Date of Birth _____ Sex _____

Eye Color _____ Hair Color _____

Racial or Ethnic Background _____

Social Security Number_____

Copies of this document are in the following places (ie., family members, doctors office, hospitals, mental health centers.....)

_____

_____

*INFORMATION RELEASE*

I have placed a copy of this document, which includes my original signature, at the following location. I authorize _____ (agency)

Address _____

City and State _____

Phone number(s)_____

to release this form upon request to the hospital where I have been admitted and/or to my mental healthcare professional and/or to my physician when it has been determined that my ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that I lack the capacity to refuse or consent to mental health treatment. This consent may be revoked in writing at any time. This consent expires automatically as described above. I acknowledge that that this consent is given of my own free will.

*SIGNATURE PAGE*

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

_____ _____

Your signature Date

_____

Printed Name

The directive above was signed and declared by the "Declarant," (your name) _____ to be his/her mental healthcare advance directive, in our presence who, at his/her request, have signed our names below as witnesses. 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 or a patient 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 _____ (county, state),

this _____day of _____, 20_____.

WITNESS SIGNATURES:

**Witness Number One**

_____ _____

Print name Signature

Home Address _____ City, State ZIP _____

**Witness Number Two**

_____ _____

Print name Signature

Home Address _____ City, State ZIP _____