DIRECTIONS FOR FILLING OUT THE FORMS

CHECKLIST OF INSTRUCTIONS. After you have finished making your advance directive selections, you should fill out the checklist indicating which sections and options you have addressed in the document. This will allow a health care provider to more easily and quickly identify the relevant sections in your advance directive that are operative should you become incompetent to make medical decisions.

SECTION I. In Section I, A-I, you are able to choose the specific mental health treatment that you want or prefer and to indicate which mental health treatment you do not want. You do not have to fill out those sections where you do not have a specific treatment preference. In addition, you may choose not to make any treatment decisions in your advance directive, but instead choose a health care agent to make decisions on your behalf should you become incompetent to make medical decisions. The agent will be required to make those decisions that he or she knows or reasonably believes that you would make if competent.

Section I-A:

1. You may list the name(s) of any psychiatric medication that you consent to take. You may also limit the dosage of any or all the medications listed. You should list any medications that you are currently taking or have taken in the past, which work well for you.

2. If you want your community physician to be involved in determining what medication is appropriate, check this box. This can be important if you are hospitalized and the treating physician is not familiar with your medical history.

3. If you want your health care agent make the decision about medication for you, subject to any restrictions that you impose, check this box.

4. If you are concerned about side effects and do not want to be prescribed medication that carries a risk of a particular side effect, you can provide for that restriction here. Check off each side effect that you are not willing to risk.

5. If you are allergic to any medications, list them here with the reactions you have had.

6. You may list any medications that you specifically do not consent to. You should list the reasons that you do not want a specific medication. For example, if you are allergic to a medication, you would list that medication and put “allergic” as the reason.

Section I-B:

1. If you do not consent to the administration of Electroconvulsive Therapy (ECT), check this box.

2. If you want your health care agent to be able to consent to ECT, check this box and then check either (a), (b) or (c). Check (a) if you want the treating physician to decide on the number of ECT treatments; check (b) if you want your community physician to decide on the number of treatments; or check (c) if you want to limit the number of treatments yourself.

3. Provide any other instructions or preferences that you have regarding ECT.

Section I-C:

1. If you do not consent to the administration of Transcranial Magnetic Stimulation (TMS), check this box.

2. If you want your health care agent to be able to consent to TMS, check this box and then check either (a), (b) or (c). Check (a) if you want the treating physician to decide on the number of TMS treatments; check (b) if you want your community physician to decide on the number of treatments; or check (c) if you want to limit the number of treatments yourself.

3. Provide any other instructions or preferences that you have regarding TMS.

Section 1-D:

1. List any other types of mental health treatment that you consent to, such as group therapy, light therapy, etc.

2. List any mental health treatment that you specifically do not want.

Section I-E:

1. If you would prefer an alternative to hospital care during a psychiatric crisis, check this box. An example of an alternative is a crisis bed in a community program, if available.

2. If you want to or have to be admitted to a hospital you can list the hospitals where you would prefer to be treated.

3. List any hospital, community program or facility that you do not want to go to and the reason why.

4. If there are any specific doctors or other mental health professionals that you do not want treating you, list them here along with the reason.

Section I-F:

1. If you do not want to participate in experiments or drug trials, check this box.

2. If you want to have your health care agent make the decision about your participation in with experimental studies/drug trials should other standard treatment fail to be effective, check this box.

Section I-G:

1. If you want close friends or family to be notified upon your admission to a hospital or other facility, list them here. VERY IMPORTANT: If you have a health care agent, list that person.

2. You may list those persons that you wish to be able to visit you in the hospital or facility. VERY IMPORTANT: If you have a health care agent, list that person.

3. You may also list those persons that you do NOT wish to visit you.

4. Under the federal law "Health Insurance Portability and Accountability Act (HIPPA), your health care agent is automatically your "personal representative" and entitled to your mental health records, medical records and to receive protected health information from a provider. In this section, you can instruct your health care agent on the individuals to whom your agent can release records and information.

Section I-H:

This section allows you to list the activities that help to calm you and make you feel better. By letting staff know of these methods, you will decrease the likelihood that you will end up in restraint or seclusion.

Section I-I:

1. Many people have histories of prior abuse, physical or mental, and are very sensitive to having other people touch them. You should check off your preferences regarding staff touching you to avoid having staff accidentally trigger a bad memory or anxiety.

2. There is also room for you to list any other preferences that you have regarding mental health care and treatment.

Section I-J:

List any other preferences that you have for mental health care.

Section 1-K:

List any co-occurring illnesses.

SECTION II. In this section, you can choose to appoint a mental health care agent. If you do not want a health care agent, skip this section and go directly to Section III.

Section II-A:
List the name and contact information for the person that you want to serve as your health care agent. Be sure to get that individual to agree to serve as your health care agent and be sure to give that person a copy of your advance directive document.

Section II-B:
List an alternate person in the event that your first choice is unable to fulfill this duty in the future. Be sure to get that individual to agree to serve as your alternate health care agent and be sure to give that person a copy of your advance directive document.

Section II-C:
1. Check this box if you want your agent to make decisions only according to what you have specifically put in this document. If you check this box, your agent will not be able to make a treatment decision that you have not planned in advance.

2. Check this box if you want your agent to make decisions on treatment even though you have not made a specific choice in this document. In this case, your agent can rely upon other written or verbal statements that you have made. If you have never indicated a preference to your agent on a particular treatment, your agent will be required to make a reasonable effort to determine what decision you yourself would make if you were competent. As a last resort, the agent may decide what he or she believes is in your best interest under the particular circumstances. In deciding your best interest, the agent will have to consider all of the risks and benefits of the proposed treatment (or withholding the proposed treatment), as well as considering whether the treatment is contrary to your personal or religious beliefs.

SECTION III. In this section, you may choose whether your advance directive is revocable or non-revocable by you during those periods when two physicians have documented in your medical record that you are not competent to make medical decisions. Under current Maryland law, all advance directives are revocable at any time. It is not yet clear whether choosing now to make your advance directive non-revocable during periods of incompetency will override any objections that you have at that time. However, if you want your advance directive to be non-revocable you should make this election as it is the strongest evidence of a free choice that you made while you are competent.

SECTION IV. Sign and date the advance directive and have two witnesses sign. The witnesses must be at least 18 years old. Your health care agent cannot serve as a witness and your witnesses cannot be your mental health or health care provider or an employee of a facility/program; or any person who would benefit from your incapacity.