Registration

I hereby submit my mental health advance directive to the Division of Mental Health Services in the New Jersey Department of Human Services to be registered. I choose the following password that will permit access for me and anyone with whom I share it.

_____ (if left blank one will be assigned and provided to you.)

I further understand that a licensed health care provider who is providing me with mental health care may be able to access my directive if needed. No other person will be permitted to see the directive (except as required for administration of the registry) without my permission.

_____ _____

Signature Print name

Please provide contact information for confirmation:

_____

(email, street address or telephone number)

Witness:

_____ _____

Signature Print name

Dated: _____

Send original to: NJDMHS Registry, 50 E. State St, PO Box 727, Trenton, NJ 08625-0727 and attach a copy of your entire mental health care advance directive. You may also submit other documents to be registered that affect your legal ability to consent, such as a health care advance directive, durable power of attorney, temporary or limited guardianship orders, etc., which the registry will accept in its discretion.

Instructions and Information

(1) This document is called an advance directive for mental health care and allows you to make decisions in advance about your mental health treatment, including medications and voluntary admission to Inpatient treatment and electroconvulsive therapy.

YOU DO NOT HAVE TO FILL OUT OR SIGN THIS FORM. IF YOU DO NOT SIGN AND DATE THIS FORM, OR IF IT IS NOT APPROPRIATELY WITNESSED, IT WILL NOT TAKE AFFECT. IF YOU DO SIGN IT, DATE IT, AND HAVITE IT WITNESSED, IT WILL TAKE EFFECT IF A DOCTOR OR ADVANCE PRACTICE NURSE DOCUMETNS THAT YOU ARE INCAPAPBLE OF MAKING TREATMENT DECISIONS.

If you choose to complete and sign this document, you may still decide to leave some items blank.

A witness cannot be your designated mental health care representative or your current treating professional. If here is only one witness, that person also can be anyone except someone to whom you are related or your cohabitant or domestic partner, anybody who is currently entitled to any part of your estate, or the operator of your congregate residence if you live in one (group home or boarding home, for example.)

(2) You have the right to appoint a person as your mental health care representative to make treatment decisions for you. You should notify your representative that you have appointed him or her, and should give him or her a copy of this document and any revisions you make to it. If you revoke or replace it, you should also tell the representative. The person you appoint has a duty to act consistently with you wishes made known by you. If your agent does not know what your wishes are, he or she has a duty to act in your best interest. Your representative has the right to withdraw from the appointment at any time.

(3) The instructions you include with this advance directive and the authority you give your representative to act will only become effective if you become incapable of making decisions about your care. Your treatment providers must still seek your informed consent at all times this it is required and you have capacity to give informed consent.

(4) You have the right to revoke this document in writing at any time you have capacity.

YOU MAY REVOKE OR CHANGE THIS DIRECTIVE WHEN YOU ARE INCAPACITATED UNLESS YOU HAVE SPECIFICALLY STATED IN THIS DIRECTIVE THAT YOU DO NOT WANT TO BE ABLE TO REVOKE OR CHANGE IT WHEN YOU ARE INCAPACITATED. IF YOU REVOKE IT WHEN YOU ARE INCAPACITATED, THE PROFESSIONALS IN CHARGE OF YOUR TREATMENT WILL PROVIDE WHAT IS IN THEIR JUDGMENT THE BEST MEDICAL TREATMENT AND YOUR WISHES, EXPRESSED HERE, WHILL HAVE NO LEGALLY BINDING EFFECT ON THEM. THEY WILL NOT HAVE THE AUTHROITY TO CONTACT YOUR MENTAL HEALTH CARE REPRESENTATIVE, AND YOUR

REPRESENTATIVE WILL NOT HAVE THE AUTHORITY TO MAKE DECISIONS ON YOUR BEHALF.

IF YOU ARE AN INPATIENT IN A PSYCHIATRIC FACILITY WHEN YOU EXPRESS A DESIRE TO REVOKE OR CHANGE YOUR DIRECTIVE, THE PHYSICIAN WILL DETERMINE WHETHER YOU ARE CAPABLE OF MAKING THAT DECISION AT THAT TIME, AND THE REVOCATION WILL NOT BE EFFECTIVE IF YOU ARE NOT CAPABLE OF REVOKING OR MODIFYING THE DIRECTIVE.

(5) You have the choice of whether to specify an expiration date. If you specify an expiration date and you are incapacitated at the time it expires, it will remain in effect until you have capacity to make treatment decisions again.

(6) You cannot use an advance directive to consent to civil commitment. The procedures that apply to your advance directive are different from those provided for in the New Jersey Screening and Commitment Law (N.J.S.A. 30:4-27.1 et seq.). However, you can designate a representative to consent to your voluntary commitment under particular conditions.

(7) If there is anything in this directive that you do not understand, you should ask someone you trust to explain it to you. Advocates at New Jersey Protection and Advocacy will also be happy to direct or assist you. You can reach them by phone at (609) 292-9742, (800) 922-7233 (if calling within New Jersey), (609) 633-7106 (TTY), or by email at advocate@njpanda.org.

(8) You should be aware that there are some circumstances where you provider may not have to follow your directive. If the provider cannot provide the treatment you designate, or if it would not be legal, ethical, or good medical practice to provide a treatment you designate, she or he will be able to deny you that treatment and substitute his or her best medical judgment, but only by seeking the approval of the hospital or agency ethics board. If a provider does not follow your directive, you and your mental health representative will be given notice and an opportunity to contest that decision.

(9) You should discuss any treatment decisions in your directive with your provider.

(10) You may register your directive with the state by completing the last page of the attached form and sending the original of that page and a copy of the advance directive to: DMHS Registry, P.O. Box 727, 50 E. State Street, Trenton, NJ 08625-0727. If you register your directive, DMHS will send you a password that will allow you or anyone with your name and that password to view the directive on the internet. Your directive will also be available to mental health professionals who have applied to the registry for access and to whom you give your name and social security number.

THIS IS ONLY ONE POSSIBLE FORM. ANY FORM OF DIRECTIVE THAT IS SIGNED, DATED AND APPROPRIATELY WITNESSED (SEE INSTRUCTIONS) IS ACCEPTABLE AND WILL BE HONORED BY NEW JERSEY MENTAL HEALTH PROFESSIONALS AND HOSPITALS.

Declaration of Mental Health Care Representative

I, _____, being a legal adult of sound mind, voluntarily make this declaration for mental health treatment. I want this declaration to be followed if I am incapable, as defined in New Jersey Statutes 26:2H-108. I designate _____ as my agent for all matter relating to my mental health care including, with limitation, full power to give or refuse consent to all medical care related to my mental health condition. If my agent is unable or unwilling to serve or continue to serve, I appoint _____ as my agent. If both are unable or unwilling to serve or continue to serve, I appoint _____ as my agent. I want my agent to make decisions for my mental health care treatment that are consistent with my wishes as expressed in this document or, if not specifically expressed, as are otherwise known to my agent.

If my wishes are unknown to my agent, I want my agent to make decisions regarding my mental healthcare that are consistent with what my agent in good faith believes to me in my best interests. My agent is also authorized to receive information regarding proposed mental health treatment and to receive, review and consent to disclosure of any medical records relating to that treatment.

I specifically authorize my representative to receive information about my treatment for HIV/AIDS and alcohol and substance abuse diagnosis and treatment if applicable and relevant. _____ (initial)

This declaration allows me to state my wishes regarding mental health care treatment including medications, admission to and retention in a health care facility for mental health treatment and outpatient services.

(Initial one of the following)

_____ This designation of a mental health care representative is irrevocable if I have been found under the standards in New Jersey Statutes Annotated 26:2H-108 to lack capacity to directly consent to my care.

_____ I can revoke this designation of a mental health care representative at all times.

If you wish to complete an instruction directive, continue on page 2. Otherwise, go to the signature section on page 5.

Mental Health Instruction Directive

The following are my wishes regarding my mental health care treatment if I become incapable.

Preferences and Instruction About Physician(s) or Other Professional to be Involved in My Treatment

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

_____ Contact information: _____

_____ Contact information: _____

I do not wish to be treated by _____ (facility or professional)

Preferences and Instructions About Other Providers

I am receiving other treatment or care from providers who I feel 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: _____ Contact Information: _____

Name: _____ Contact Information: _____

Preferences and Instructions About Medications for Psychiatric Treatment

___ I consent and authorize my mental health care representative, if appointed on page 1, to consent to the administration of the following medications:

_____

___ I do not consent to, and I do not authorize my mental health care representative to consent to the administration of any of the following medications:

_____

___ I am willing to take the medication excluded above if my only reason for excluding them is the side effects which include: _____ and these side effects can be eliminated by dosage adjustments or other means.

____ I am willing to try any other medication the hospital doctor recommends.

____ I am willing to try any other medications my outpatient doctor recommends.

____ I am not willing to try any other medications.

Preferences About Voluntary Hospitalization and Alternatives:

By initialing here, I consent to giving my representative the power to admit me to an inpatient or partial psychiatric hospitalization program for up to ____ days.

____ (initial if you consent)

I would like the interventions below to be tried before voluntary hospitalization is considered:

____ Calling someone or having someone call me when needed. (Name _____ telephone number: _____)

____ Staying overnight at a crisis respite (temporary) bed.

____ Having a mental health care provider come to see me.

____ Staying overnight with a friend: _____

____ Seeing a mental health care provider for assistance with medications

____ Other: _____

If hospitalization is required, I prefer the following hospital(s):

_____

Preferences About Emergency Interventions

I would like the interventions below to be tried before use of seclusion or restraint is considered (check all that apply)

____ "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
___ other: _____

If it is determined that I am engaging in behavior that requires seclusion, physical restraint, and/or emergency use of medication, I prefer these interventions in the order I have chosen (choose "1" for first choice, "2" for second choice and so on.)

___ Seclusion ___ Seclusion and physical restraint (combined)

___ Medication by injection ___ Medication in pill or liquid form

In the event that my attending physician decides to use medication in response to an emergency situation after due consideration of my preferences and instructions for emergency treatments stated above, I expect the choice of medication to reflect any preferences and instructions I have expressed in this form. The preferences and instructions I express in this section regarding medication in emergency situations do not constitute consent to use of the medication for nonemergency treatment.

Preferences and Instructions About Electroconvulsive Therapy (ECT or Shock Therapy)

___ I wish my mental health care representative to be able to consent to electroconvulsive therapy in his or her complete discretion.

___ I wish my mental health care representative to be able to consent to electroconvulsive therapy if I display the following symptoms:

_____

___ I do not authorize my representative to consent to electroconvulsive therapy.

Expiration

This advance directive for mental health care is made pursuant to P.L. 2005, ch 233 of the New Jersey laws and constitutes in effect for all who may rely on it except to those I have given notice of its revocation pursuant to NJSA 26:2h-106 d. (1). If I do not revoke the directive, it will expire on _____, 20___. (leave blank if you do not want it to expire.)

Signatures

I have voluntarily completed this advance directive for mental health care.

_____ (signature of declarant)

Address of mental health care representative: _____

Telephone number of mental health care representative: _____

Address(es) of alternate mental health care representative(s):

_____

Telephone number(s) of alternate mental health care representative(s):

_____

Affirmation of first witness (required):

I affirm that the person signing this mental health care advance directive:

1. Is personally known to me.
2. Signed or acknowledged by his or her signature on the declaration in my presence.
3. Appears to be of sound mind and not under duress, fraud or undue influence.
4. Is not related to me by blood, marriage or adoption.
5. Is not a person for whom I directly provide care as a professional.
6. Has not appointed me as an agent to make medical decisions on his or he behalf.

Witnessed by:

_____ _____, 20____

Affirmation of second witness: (two witnesses are required if the first witness is related to the declarant, entitled to any part of the declarant's estate, or the operator, administrator or employee of a rooming or boarding house or a residential health care facility in which the declarant resides)

I affirm that the person signing this mental health care advance directive:

1. Is personally known to me.
2. Signed or acknowledged by his or her signature on the declaration in my presence.
3. Appears to be of sound mind and not under duress, fraud or undue influence.
4. Is not related to me by blood, marriage or adoption.
5. Is not a person for whom I directly provide care as a professional.
6. Has not appointed me as an agent to make medical decisions on his or he behalf.

Witnessed by:

_____ _____, 20____

Acceptance of appointment as agent: (optional)

I accept this appointment and agree to serve as agent to make mental health treatment decisions for the principal. I understand that I must act consistently with the wishes of the person I represent, as expressed in this mental health care power of attorney, or if not expressed, as otherwise known by me. If I do not know the principal's wishes, I have a duty to act in what I in good faith believe to be that person's best interests. I understand that this document give me the authority to make decisions about mental health treatment only while that person has been determined to be incapable as that term is defined in NJSA 26:2H-109.

_____

signature of primary mental health care representative

_____

printed name of primary mental health care representative

_____

signature of first alternate mental health care representative

_____

printed name of first alternate mental health care representative

_____

signature of second alternate mental health care representative

_____

printed name of second alternate mental health care representative

Revocation

Complete this section if you wish to revoke this directive completely. You may also revoke or modify the directive by executing a new document. If you do so, you should tell your mental health care representative and replace the old documents in anyone's possession with your new directive. If you revoke this directive, it will no longer have any legal effect on your treatment.

____ I revoke the mental health advance directive I executed on or about _____, 20____ in its entirety.

_____ _____

(signature) (date)