ADVANCED DIRECTIVE FOR PSYCHIATRIC CARE

Pursuant to NRS 449A.621

An Advanced Directive for Psychiatric Care, sometimes called a "PAD," is a document that states your wishes for your psychiatric care in the event that you become incapable of making or communicating treatment decisions. It is like a Power of Attorney, but specific to psychiatric care. In the PAD, you can describe your preferences for treatment or who you choose to be your "agent," the person in charge of your psychiatric decision-making.

Read through the Frequently Asked Questions below. Then, to complete the PAD, follow the instructions after the FAQ.

Frequently Asked Questions

Q: Can I write a legally binding PAD?

A: Yes, as long as you are of sound mind and at least 18 years old. The form in this packet, when completed properly, can act as a legally binding PAD.

Q: What kinds of instructions regarding psychiatric medications and/or hospitalization go into the PAD?

A: You can write instructions for which psychoactive mediations you may want and specify the administration of those medications. You can also name which medications you would *not* want. You can also describe what medical facilities you prefer or do not prefer and the maximum number of days you consent to be admitted. You can also list several preferences and helpful information for the staff at the medical facility should you be admitted.

Q: Who should I appoint as an agent to make mental health decisions for me if I become incompetent?

A: You should appoint someone you trust. There may come a time when your agent has to decide between what he/she thinks you would want versus what he/she thinks is best for you. Choose someone you can communicate openly with, so that your agent knows how to behave if the time should come to make those kinds of decisions.

Q: Do I have to know all my preferences and fill out the entire PAD?

A: You can limit your PAD to what you know you want. In other words, you can fill out information about treatment decisions, but not name an agent. Alternatively, you can simply name an agent without specific instructions.

Q: Do I have to file my PAD to make it official?

A: After you and your witnesses have signed the PAD with a notary present, the PAD becomes an official document. You should present a copy to your attending physician and health care providers so that they can make it a part of your medical records. Then, you should register it with the Nevada Secretary of State. More information on this is in Step 4 in the Instructions.

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Q: How will it be decided that I am not competent to make certain decisions for my PAD to be used? Does a court get involved?

A: The PAD will become operative when two providers of health care determine that you are incapable of making or communicating treatment decisions. One must be a physician or licensed psychologist, a psychiatrist, or an advance practice registered nurse who has specific psychiatric training. Once those two health care professionals determine that you are incapable, your instructions in the PAD should be followed. A court does not need to get involved at this stage.

Q: Does anyone have to approve my PAD?

A: No, but you will need two witnesses who you know, who will watch you sign the PAD. The witnesses cannot be:

- your attending physician or health care provider, or an employee of theirs,
- an owner or operator of a medical facility in which you are a patient or resident, or an employee of that owner or operator, or
- the person appointed as your agent within the PAD.

Q: Can my mental health providers decide not to follow my PAD?

A: Mental health providers can decide not to follow your PAD only if:

- Compliance, in the opinion of the attending physician or other provider, is not consistent with generally accepted standards of care for the provision of psychiatric care for your benefit;
- Compliance is not consistent with the availability of psychiatric care requested;
- Compliance is not consistent with applicable law;
- You are admitted to a mental health facility or hospital as an emergency admission or as an involuntary court-ordered admission, and a course of treatment is required because of that type of admission; or
- Compliance, in the opinion of the attending physician or other provider, is not consistent with appropriate psychiatric care in case of an emergency endangering your life or health, or the life or health of another person.

If one part of the PAD cannot be followed, the other parts should be followed.

Q: How long does the PAD remain valid?

A: The PAD remains valid for 2 years after you sign it, unless you revoke it. You can change it or revoke it when you are of sound mind and you notify your physician or health care provider of the revocation.

Q: How can I find more information about PADs?

A: Nevada Revised Statutes 449A.600 — 449A.645 explain PADs, and sections 449A.700 — 449A.739 covers registration.

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Instructions for Completing the PAD

Step 1: Gather information.

In order for this document to be completed, you will answer questions regarding your wishes for psychiatric care. *You do not have to know the answer to every question.* But before beginning, you should consider:

- What medications you would want to take and which you would not.
    - You can agree to take:
        - Any medications your doctor recommends for treatment of your psychiatric condition;
        - Any medications your doctor recommends for treatment of your psychiatric condition with specified exceptions;
        - Only particular medications specified by name.
    - You can also refuse to take any psychotropic/psychiatric medications.
- The name of the facility you prefer for your psychiatric care, or the name of the facility you would not want to be admitted to. Note that your choice of facility may not be covered by your insurance.
- The information – including name, address, home and work phone – of up to two individuals who you would want to serve as your agents;
- The name and office number of your physician;
- The name and office number of your therapist and/or counselor;
- If you consent to electroconclusive (ETC) treatment ("shock treatment");

You may also answer questions about your behavior, such as:

- Things that might cause or worsen a serious mental crisis;
- Steps that would help to avoid hospitalization if it gets to that;
- Your reaction to hospitalization;
- Advice to staff about helping you be more comfortable during hospitalization;
- Who you chose to visit you during your hospitalization.

Step 2: Fill out the PAD with your gathered information.

Do not leave any lines blank. If something does not apply to you because you do not have an instruction or preference, write in "N/A" or "None."

Step 3: Sign the PAD.

Initial pages 1-9 in the initial box on the bottom right of each page.
Sign page 8 of the PAD with two witnesses and a notary public watching you.

Step 4: Register the PAD.

To register the PAD:

- Go to: nvsos.gov/sos/online-services/Nevada-lockbox/file-advance-directive
- Follow the instructions on that page for sending a copy of the PAD to the Lockbox.

Step 5: Give a copy of your PAD to your physician or regular health care providers.
Giving a copy of your PAD to your physician or health care providers will ensure that it gets put into your medical record.

Step 6: Let your loved ones know about the PAD.
After registering the PAD, you'll get a registration card which will show a registration number. Give copies of your PAD and share your registration number with your trusted loved ones so that they know how to honor your wishes should the time come to do so.

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NOTICE TO PERSON MAKING AN ADVANCE DIRECTIVE FOR PSYCHIATRIC CARE

This is an important legal document. It creates an Advance Directive for psychiatric care. Before signing this document, you should know these important facts:

This document allows you to make decisions in advance about certain types of psychiatric care. The instructions you include in this Advance Directive will be followed if two providers of health care, one of whom must be a physician or licensed psychologist and the other of whom must be a physician, a physician assistant, a licensed psychologist, a psychiatrist or an advanced practice registered nurse who has the psychiatric training and experience prescribed by the State Board of Nursing pursuant to NRS 632.120, determines that you are incapable of making or communicating treatment decisions. Otherwise you will be considered capable to give or withhold consent for the treatments. Your instructions may be overridden if you are being held in accordance with civil commitment law. By executing a durable power of attorney for health care as set forth in NRS 162A.700 to 162A.870, inclusive, you may also appoint a person as your agent to make treatment decisions for you if you become incapable. This document is valid for two years from the date you execute it unless you revoke it. You have the right to revoke this document at any time you have not been determined to be incapable. You may not revoke this advance directive when you are found incapable by two providers of health care, one of whom must be a physician or licensed psychologist and the other of whom must be a physician, a physician assistant, a licensed psychologist, a psychiatrist or an advanced practice registered nurse who has the psychiatric training and experience prescribed by the state board of nursing pursuant to NRS 632.120. A revocation is effective when it is communicated to your attending physician or other health care provider. The physician or other provider shall note the revocation in your medical record. To be valid, this Advance Directive must be signed by two qualified witnesses, personally known to you, who are present when you sign or acknowledge your signature. It must also be acknowledged before a notary public.

NOTICE TO PHYSICIAN OR OTHER PROVIDER OF HEALTH CARE

Under Nevada law, a person may use this Advance Directive to provide consent or refuse to consent to future psychiatric care if the person later becomes incapable of making or communicating those decisions. By executing a durable power of attorney for health care as set forth in NRS 162A.700 to 162A.870, inclusive, the person may also appoint an agent to make decisions regarding psychiatric care for the person when incapable. A person is "incapable" for the purposes of this Advance Directive when in the opinion of two providers of health care, one of whom must be a physician or licensed psychologist and the other of whom must be a physician, a physician assistant, a licensed psychologist, a psychiatrist or an advanced practice registered nurse who has the psychiatric training and experience prescribed by the State Board of Nursing pursuant to NRS 632.120, the person currently lacks sufficient understanding or capacity to make or communicate decisions regarding psychiatric care. If a person is determined to be incapable, the person may be found capable when, in the opinion of the person's attending physician or an advanced practice registered nurse who has the psychiatric training and experience prescribed by the State Board of Nursing pursuant to NRS 632.120 and has an established relationship with the person, the person has regained sufficient understanding or capacity to make or communicate decisions regarding psychiatric care. This document becomes effective upon its proper execution and remains valid for a period of 2 years after the date of its execution unless revoked. Upon being presented with this Advance Directive, the physician or other provider of health care must make it a part of the person's medical record. The physician or other provider must act in accordance with the statements expressed in the advance directive when the person is determined to be incapable, except as otherwise provided in NRS 449A.636. The physician or other provider shall promptly notify the principal and, if applicable, the agent of the principal, and document in the principal's medical record any act or omission that is not in compliance with any part of an advance directive. A physician or other provider may rely upon the authority of a signed, witnessed, dated and notarized advance directive.

INITIALS: _____

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I, *(insert your name)* _____, being an adult of sound mind or an emancipated minor, willfully and voluntarily make this advance directive for psychiatric care to be followed if it is determined by two providers of health care, one of whom must be my attending physician or a licensed psychologist and the other of whom must be a physician, a physician assistant, a licensed psychologist, a psychiatrist or an advanced practice registered nurse who has the psychiatric training and experience prescribed by the State Board of Nursing pursuant to NRS 632.120, 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 psychiatric care. I understand that psychiatric care may not be administered without my express and informed consent or, if I am incapable of giving my informed consent, the express and informed consent of my legally responsible person, my agent named pursuant to a valid durable power of attorney for health care or my consent expressed in this advance directive for psychiatric care. I understand that I may become incapable of giving or withholding informed consent or refusal for psychiatric care due to the symptoms of a diagnosed mental disorder.

Symptoms of my diagnosed mental disorder that may render me incapable of giving or withholding informed consent or refusal for psychiatric care may include *(list the symptoms of your diagnosed mental disorder):*

_____

_____

_____

PSYCHOACTIVE MEDICATIONS

If I become incapable of giving or withholding informed consent for psychiatric care, my instructions regarding psychoactive medications are as follows:

I consent to receiving the following medication(s) if I am incapable of giving or withholding informed consent for psychiatric care *(list the medications you consent to receiving; write "none" if none)*:

_____

_____

I do ***not*** consent to the administration of the following medications *(list the medications you do **not** consent to receiving; write "none" if none)*:

_____

_____

INITIALS: _____

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ADMISSION TO AND RETENTION IN FACILITY

If I become incapable of giving or withholding informed consent for psychiatric care, my instructions regarding admission to and retention in a medical facility for psychiatric care are as follows:

Consent to voluntary admission:

(check one box, and complete any information requested after the box you check)

☐ I do consent to being in a medical facility for psychiatric care for the duration of time recommended by my treating physician.

☐ I do consent to being in a medical facility for psychiatric care.
The duration of my stay in the medical facility for psychiatric care should not be more than *(write number of days you consent to be admitted)* _____ days.

☐ I do *not* consent to being admitted to a medical facility for psychiatric care.

Whether voluntary or involuntary admission, my facility preference is:

(name of facility you prefer) _____

(street address of facility) _____

(city, state, zip of facility) _____

I would **NOT** want to be admitted to the following facility:

*(name of facility you do **not** prefer)* _____

(street address of facility) _____

(city, state, zip of facility) _____

This advance directive cannot, by law, provide consent to retain me in a facility beyond the specific number of days, if any provided in this advance directive.

The conditions or limitations I set forth regarding admission in a facility include *(state any conditions or limitations you have regarding facility admission)*:

_____

_____

_____

INITIALS: _____

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ADDITIONAL INSTRUCTIONS

These instructions shall apply during the entire length of my incapacity.

In case of a mental health crisis, please contact *(complete contact information for your chosen agents)*:

Name: _____

Address: _____

_____

Home Telephone: _____

Work Telephone: _____

Relationship to Me: _____

Name: _____

Address: _____

_____

Home Telephone: _____

Work Telephone: _____

Relationship to Me: _____

(Complete contact information for your physician and therapist/counselor below.)

My Physician's name: _____

Physician's number: _____

My Therapist/Counselor name: _____

Therapist/Counselor number: _____

(Complete the following information about other details regarding a mental health crisis.)

The following may cause me to experience a mental health crisis *(list the things that might cause you to have a mental health crisis)*:

_____

_____

_____

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The following may help me avoid a hospitalization *(state anything that your loved ones should know that might help you avoid being hospitalized)*:

_____

_____

_____

I usually react to being hospitalized as follows *(describe how you generally react to being hospitalized)*:

_____

_____

_____

Staff at the hospital or crisis unit can help me by doing the following *(state anything the hospital or facility staff should know to be most helpful to you)*:

_____

_____

_____

I give permission for the following person or people to visit me *(list the people you would allow to visit you if you were hospitalized or in a facility)*:

_____

_____

_____

(check one)

☐ I do ***not*** consent to "shock treatment" or electroconvulsive (ECT) treatment.

☐ I consent to "shock treatment" or electroconvulsive (ECT) treatment.

INITIALS: _____

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NON-TREATMENT PREFERENCES

If I become incapable of giving or withholding informed consent for psychiatric care, my instructions regarding non-treatment preferences are as follows:

DIET

My dietary preferences include *(state any dietary restrictions or preferences)*:

_____

_____

_____

ASSISTIVE TECHNOLOGY/DEVICES

My preferences regarding assistive technology and devices include *(describe what technology you would want and if there are any limitations; this can include phones, watches, tablets, sleep aids, etc.)*:

_____

_____

_____

SERVICE ANIMALS

My preferences regarding service animals include *(describe your preferences regarding any service animals, and how you would like those animals to be taken care of, and by whom)*:

_____

_____

_____

RELIGION

My religious preferences include *(describe any inclusions or exclusions regarding religion; what religious practices you do or do not prefer)*:

_____

_____

_____

INITIALS: _____

SHARING OF INFORMATION BY PROVIDERS

I understand that the information in this document may be shared by my provider of mental health care with any other provider who may serve me when necessary to provide treatment in accordance with this advance directive.

I have other instructions about the sharing of information, and they are as follows *(state any instructions you have about who you wish or do not wish to share information with, or any conditions/limitations on this; if none, write "none")*:

_____

_____

_____

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SIGNATURE OF PRINCIPAL

By signing here, I indicate that I am mentally alert and competent, fully informed as to the contents of this document, and understand the full impact of having made this advance directive for psychiatric care.

_____

(your signature) Signature of Principal

_____

(your name) Principal

_____

(date you are signing) Date

AFFIRMATION OF WITNESSES

We affirm that the principal is personally known to us, that the principal signed or acknowledged the principal's signature on this advance directive for psychiatric care in our presence, that the principal appears to be of sound mind and not under duress, fraud, or undue influence, and that neither of us is: (1) A person appointed as an attorney-in-fact by this document; (2) The principal's attending physician or provider of health care or an employee of the physician or provider; or (3) The owner or operator, or employee of the owner or operator, of a medical facility in which the principal is a patient or resident.

Witnessed by:

_____

Witness Signature

_____

Witness Name

_____

Date

Witnessed by:

_____

Witness Signature

_____

Witness Name

_____

Date

INITIALS: _____

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CERTIFICATION OF NOTARY PUBLIC

I, _____, a Notary Public for the County cited above in the State of Nevada, hereby certify that _____ appeared before me and swore or affirmed to me and to the witnesses in my presence that this instrument is an advance directive for psychiatric care and that he or she willingly and voluntarily made and executed it as his or her free act and deed for the purposes expressed in it.

I further certify that _____ and _____, witnesses, appeared before me and swore or affirmed that each witnessed _____ sign the Advanced Directive for psychiatric care believing him or her to be of sound mind and also swore that at the time each witnessed the signing, each person was (1) not the attending physician or provider of health care, or an employee of the physician or provider, or of the principal; (2) not the owner or operator, or employee of the owner or operator, of a medical facility in which the principal is a patient or resident; and (3) not a person appointed as an attorney-in-fact by the Advanced Directive for Psychiatric Care. I further certify that I am satisfied as to the genuineness and due execution of the instrument.

SUBSCRIBED AND SWORN to before me
this ___ day of _____, 20___.

_____
__ NOTARY PUBLIC in and for the County of
_____, State of _____

INITIALS: _____