ADVANCE MENTAL HEALTH CARE DIRECTIVE

I, _____, being an adult nineteen years of age or older and of sound mind, freely and voluntarily make this directive for mental health care to be followed if it is 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 care. "Mental health care" includes, but is not limited to, treatment of mental illness with psychotropic medication, admission to and retention in a treatment facility for a period up to 21 days, or electroconvulsive therapy.

I understand that I may become incapable of giving or withholding informed consent for mental health care due to the symptoms of a diagnosed mental disorder. These symptoms may include, but not be limited to: _____

_____

PSYCHOTROPIC MEDICATIONS

If I become incapable of giving or withholding informed consent for mental health care, my wishes regarding psychotropic medications, including classes of medications if appropriate, are as follows (check one or both of the following, if applicable):

☐ I consent to the administration of the following medications:

_____

_____

_____

☐ I do not consent to the administration of the following medications:

_____

_____

Conditions or limitations, if any:

_____

_____

ADMISSION TO AND RETENTION IN FACILITY

If I become incapable of giving or withholding informed consent for mental health care, my wishes regarding admission to and retention in a health care facility for mental health care are as follows (check one of the following, if applicable):

☐ I consent to being admitted to a treatment facility for mental health care.

☐ I do not consent to being admitted to a treatment facility for mental health care.

This directive cannot, by law, provide consent to retain me in a treatment facility for more than 21 days.

Conditions or limitations, if any:

_____

_____

ELECTROCONVULSIVE THERAPY

If I become incapable of giving or withholding informed consent for mental health care, my wishes regarding electroconvulsive therapy are as follows (check one of the following, if applicable):

☐ I consent to the administration of electroconvulsive therapy.

☐ I do not consent to the administration of electroconvulsive therapy.

Conditions or limitations, if any:

_____

_____

DESIGNATION OF IRREVOCABILITY DURING INCAPACITY

If I become incapable of giving or withholding informed consent for mental health care, my advance mental health care directive remains irrevocable during such period of incapacity:

☐ Yes

☐ No

If yes, the directive is irrevocable during such period of incapacity with regard to:

☐ Admission and retention in a treatment facility for mental health care for up to 21 days;

☐ Psychotropic medication as follows:

_____

_____

☐ Electroconvulsive therapy; or

☐ All of the above.

If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you. This directive will not be valid unless it is signed in the presence of a notary public or signed by two qualified witnesses who are either personally known to you or verify your identity and who are present when you sign or acknowledge your signature.

SELECTION OF PHYSICIAN (OPTIONAL)

If it becomes necessary to determine if I have become incapable of giving or withholding informed consent for mental health care, I choose_____

of_____
(address of licensed physician) to be one of the two licensed physicians who will determine whether I am incapable. If that licensed physician is unavailable, that physician's designee shall serve as one of the two licensed physicians who will determine whether I am incapable.

ADDITIONAL REFERENCES OR INSTRUCTIONS

_____

_____

Conditions or limitations, if any:

_____

_____

This document will continue in effect until you revoke it as described below or until a date you designate in this document. If you wish to have this document terminate on a certain date, please indicate:

_____
(Date of expiration of directive)

_____
(Signature of Principal)

_____
(Printed Name of Principal)

_____
(Date signed)

THIS DOCUMENT MUST BE SIGNED IN THE PRESENCE OF WITNESSES OR SIGNED IN THE PRESENCE OF A NOTARY PUBLIC. COMPLETE THE APPROPRIATE PORTION WHICH FOLLOWS:

AFFIRMATION OF WITNESSES

We affirm that the principal is personally known to us or the principal presented identification, that the principal signed this advance mental health care directive in our presence or, if the principal was unable to sign the directive, the principal's designated representative signed the directive in our presence, that the principal did not appear to be incapacitated or under duress or undue influence, and that neither of us is:

(a) The principal's attending physician or a member of the principal's mental health treatment team;
(b) The principal's spouse, parent, child, grandchild, sibling, presumptive heir, or known devisee at the time of the witnessing;
(c) In a romantic or dating relationship with the principal;
(d) The attorney in fact of the principal or a person designated to make mental health care decisions for the principal; or
(e) The owner, operator, employee, or relative of an owner or operator of a treatment facility at which the principal is receiving care.

Witnessed By:

_____	_____
(Signature of Witness)	(Signature of Witness)
_____	_____
(Printed Name of Witness)	(Printed Name of Witness)
_____	_____
(Date)	(Date)

OR COMPLETE THE FOLLOWING PORTION IF THIS DOCUMENTIS SIGNED IN THE PRESENCE OF A NOTARY PUBLIC

State of Nebraska.
) ss.
County of _____

On this, the _____ day of _____ 20_____, before me, _____ a notary public in and for _____ County, personally came _____, personally to me known to be the identical person whose name is affixed to the above advance mental health care directive as principal, and I declare that such person appears in sound mind and not under duress or undue influence, that such person acknowledges the execution of the same to be such person's voluntary act and deed, and that I am not the attorney in fact of the principal designated by any power of attorney for health care.

Witness my hand and notarial seal at _____ in such county the day and year last above written.

_____
Seal Signature of Notary Public

NOTICE TO PERSON MAKING AN ADVANCE MENTAL HEALTH CARE DIRECTIVE

This is an important legal document. It creates an advance mental healthcare directive. Before signing this document, you should know these important facts:

- This document allows you to make decisions in advance about mental healthcare, including administration of psychotropic medication, short-term (up to 21days) admission to a treatment facility, and use of electroconvulsive therapy. The instructions that you include in this advance mental health care directive will be followed only if you are incapable of making treatment decisions. Otherwise, you will be considered capable to give or withhold consent for the treatments.
- If you have an attorney in fact appointed under a power of attorney for health care, your attorney in fact has a duty to act consistent with your desires as stated in this document or, if your desires are not stated or otherwise made known to the attorney in fact, to act in a manner consistent with what your attorney in fact in good faith believes to be in your best interest. The person has the right to withdraw from acting as your attorney in fact at any time.
- You have the right to revoke this document in whole or in part at any time you have been determined to be capable of giving or withholding informed consent for mental health care. A revocation is effective when it is communicated to your attending health care professional in writing and is signed by you. The revocation may be in a form similar to the following:

REVOCATION

I, _____, knowingly and voluntarily revoke my advance mental health care directive as indicated (check one of the following):

☐ I revoke my entire directive.

☐ I revoke the following portion or portions of my directive:

_____

_____
(Signature of Principal)

_____
(Printed Name of Principal)

_____
(Date)

EVALUATION BY HEALTH CARE PROFESSIONAL
(OPTIONAL)

I, _____, have evaluated the principal and determined that the principal is capable of giving or withholding informed consent for mental health care.

_____
(Signature of health care professional)

_____
(Printed Name of health care professional)

_____
(Date)