PSYCHIATRIC ADVANCE DIRECTIVE

NAME (LEGAL)
DOB
CHOSEN NAME (If different than legal.)
PRONOUNS

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CRITICAL PHYSICAL MEDICAL CONDITIONS

A. Chronic Medical Conditions

1. Liver disease
2. High blood pressure

B. Allergies

1. Penicillin
2. Peanuts

C. Prescription Medications

Non-Psychiatric Prescriptions

1. Lisinopril. 20 mg for blood pressure in the morning.
2. Estrogen.
3. Testosterone blocker.
4. ***It is critical that I continue to have uninterrupted access to hormone replacement therapy or other gender affirming medical care. A disruption to my hormone replacement therapy or other gender affirming medical care will cause me to have (insert medical side effect) and will be very detrimental to my mental health.***

Psychiatric Prescriptions

1. Lithium. 600 mg. I had Lithium toxicity in 2019. It is very important that my lithium levels are kept between .07 and 1.1.

D. Over the Counter Medications

1. Vitamin B 12

E. Dietary Restrictions and Special Needs

1. Vegetarian
2. Dentures

F. Wellness Tools for Physical Medical and Chronic Conditions

1. Exercise. I try to take walks every day to help with my diabetes.
2. Hydration. It is very important that I drink a lot of water so I can stay hydrated.

INFORMATION FOR LAW ENFORCEMENT AND CRISIS WORKERS

NAME (LEGAL)
DOB
CHOSEN NAME (If different than legal.)
PRONOUNS

I have emphysema. I have back injuries. Physical engagement is very dangerous for me.

I sometimes see and hear things that other people do not. I may take extra time to respond. I want to cooperate.

Things that may help de-escalate the situation:

1. Please tell me who you are and why you are here.
2. Please tell me what you need from me.
3. Please be patient. I may need more time to respond.
4. Please have a woman speak with me. I have a history of trauma.
5. Please remain in front of me. Please stay within my direct line of sight. Please do not move beyond 45 degrees to either side of my body.
6. Please tell me the month, day and year.

Things that may escalate the situation:

1. Please avoid physical contact as much as possible.
2. If you are going to touch me, please tell me you are going to do so and give me a time to prepare.
3. Please do not move out of my direct line of sight. Please do not move beyond 45 degrees to either side of my body.
4. Please do not stand behind me.
5. Please do not block me in with my back against a wall.
6. Please do not yell.

Transportation:

1. I have motion sickness. Please provide air for my face.
2. Please do not put me in handcuffs. If you do put me in handcuffs, please cuff me in the front of my body due to my back injury.

EFFECTIVE COMMUNICATION

Based on the Americans with Disabilities Act, as a person with a disability, I am requesting the following communication accommodations.

The following things will help people to communicate effectively with me.

1. Please reduce background noise. I have a hard time focusing with noise distractions.
2. If you don't understand what I am saying, please let me know and ask, what do you mean by… ? What do you mean by… ?
3. Please be patient. Sometimes I need to take extra time to think through what you are saying and the way I need to respond.
4. Please try to meet with me in the morning. My brain works best in the morning.
5. Please keep rescheduling as an option. I may just be having a bad day or need to sleep.
6. Please listen.
7. Please allow me to take breaks when I need to do so.
8. I am triggered by crowds. Please only have the necessary participants present.

The following things will make communication more difficult.

1. Noises, crowds and heat make it very difficult for me to concentrate. Many times, people think I can't communicate with them when I just can't focus because sensory problems are holding my attention.
2. I am triggered by crowds. I have PTSD. I will not be able to participate at my best if I am in a crowded courtroom.
3. If my sleep is interrupted, I may have a hard time communicating.
4. Rushing me can disrupt my thought process and make it difficult to focus and express myself.
5. I may not understand the words you are using or the way you explain yourself. If I don't seem to understand please try a different way to say the same thing.

For any legal proceeding, I am requesting a *peer support specialist to act as my supporter.** *(*And/or other supporter – typically a trusted family member.)*

For any legal representation, I am requesting a *peer support specialist to act as my supporter.** *(*And/or other supporter – typically a trusted family member.)*

During any mental health evaluation connected with a legal proceeding or representation, I am requesting a *peer support specialist to act as my supporter to help me to obtain information, review my options and communicate my decisions.** *(*And/or other supporter – typically a trusted family member.)*

DECLARATION FOR MENTAL HEALTH TREATMENT
IN A PSYCHIATRIC HOSPITAL

INFORMED CONSENT TO TREATMENT EVEN IF
NOT LEGALLY INCAPACITATED

I, Name of client, being an adult of sound mind, willfully and voluntarily make this declaration for mental health treatment to be followed if it is determined by a court, or by a medical professional, that my ability to understand the nature and consequences of a proposed treatment, including the benefits, risks, and alternatives to the proposed treatment, is impaired to such an extent that I lack the capacity to make mental health treatment decisions. "Mental health treatment" means electroconvulsive or other convulsive treatment, treatment of mental illness with psychoactive medication, and preferences regarding emergency mental health treatment.

In the event that a guardian or other decision-maker is appointed by a court to make health care decisions for me, I intend this document to take precedence over all other means of ascertaining my intent while competent.

By this document, I intend to create a declaration for mental health treatment as authorized by Texas Mental Health Code, CPRC § 137.002, the U.S. Constitution and the Federal Patient Self-Determination Act of 1990 (P.L. 101-508) to indicate my wishes regarding mental health treatment.

A physician or other health care provider shall act in accordance with my wishes in this Declaration for Mental Health Treatment if I am found to be incapacitated by a court or by a medical professional. If I am not incapacitated, a physician or other provider shall continue to seek and act in accordance with my informed consent if I am capable of providing informed consent. Texas Mental Health Code, CPRC § 137.004.

On being provided a copy of this Declaration for Mental Health Treatment, a physician or other health care providers shall make the declaration a part of my medical record. A physician or other health care provider shall comply with my wishes as expressed in this Declaration for Mental Health Treatment to the fullest extent possible. Texas Mental Health Code, CPRC § 137.007(a).

My wishes expressed in this document supersede any contrary or conflicting instructions given by a durable power of attorney or a guardian. Texas Mental Health Code, CPRC § 137.009 (a)(1); 137.009(a)(2).

My wishes regarding medication preferences as expressed in this document shall be used as my preference in a medication hearing under Texas Health and Safety Code, CPRC § 574.106; 137.009(b).

PSYCHOACTIVE MEDICATIONS

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

I am **currently** taking the following psychoactive medication:

1. Lithium. 600 mg regular release. Three times per day. Morning, lunch, bedtime.

Conditions or limitations: I cannot take Lithium extended release as it does not work for me. I must take the regular release.

I consent to the use of the following medications:

1. Abilify. Abilify has been helpful for me in the past. I do not want to take it as an injection. Please do not try to force me to take the injection. I will take the pills. I really dislike needles.
2. Clozaril. I found Clozaril very helpful in the past. It reduced the voices and made my life a lot better. But I will need help with the arrangements for the weekly blood work.

I do **not** consent to the following medications:

1. Haldol. Haldol makes me sleep all the time. Even when I am awake, I feel like I am sleeping. Haldol makes me feel like I am not human.
2. Seroquel. Seroquel makes me so lethargic that I have a hard time even moving my arms. It makes it difficult to do even basic tasks.

Non-Psychiatric medication, treatment, and factors essential to my mental and physical health:

It is critical that I continue to have uninterrupted access to hormone replacement therapy or other gender affirming medical care. A disruption to my hormone replacement therapy or other gender affirming medical care will cause me to have (*insert medical side effect*) and will be very detrimental to my mental health.

1. Estrogen. (Add specifics of type, dose, time of day)
2. Testosterone blocker. (Add specifics of type, dose, time of day)

Housing or detaining me in gendered facilities of the gender with which I do not identify is detrimental to my mental health. Whenever possible I would like to be housed with my identified gender or kept in isolation.

Additional treatments and wellness tools I find helpful:

1. Cognitive behavioral therapy.
2. Exercise and eating 4-5 pieces of produce per day.
3. Peer support groups.

Things that are important to me when I am considering medication options:

1. I like to be able to read. I would like to go back to school. Some medication makes it difficult for me to focus. I do not want to take medicine that means I cannot focus well enough to be able to read.
2. I like to take walks. Some medication makes it difficult for me to move well and I feel unsteady. Walking is very important to me. I do not want to take medication that makes me not able to take walks.
3. I do not want to take a medication that makes me gain weight. I have knee problems and the extra weight will make it difficult for me to walk.
4. I do not want to take a medication that makes me shake.
5. I would like to try a medication that would help me with concentration.

CONVULSIVE TREATMENT

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

I do **not** consent to the administration of convulsive treatment.

Conditions or limitations: There are no conditions or limitations. I do **not** consent to convulsive treatment.

PREFERENCES FOR EMERGENCY TREATMENT

In an emergency, I prefer the treatment in the following order:

FIRST: Medications

SECOND: Seclusion

THIRD: Restraint. I have emphysema. Restraining me could cause me not to be able to breathe. I have a traumatic brain injury. I have back injuries. Being restraining could harm me.

Options for treatment prior to use of medications, seclusions and/or restraint:

Prior to the use of medications, seclusion or restraint, I would like staff to try to communicate with me in the following manner and/or try the following techniques to de-escalate the situation:

Things that may help calm the situation:

1. Please call me, Mary, even though it is not my legal name.
2. Please use my chosen pronouns, she/her.
3. Please ask me what is wrong.
4. Please speak to me in a soft tone of voice.
5. Please have a woman communicate with me.
6. Please do not touch me.
7. Please ask me if I would like to speak one on one in a separate room.
8. Please ask me if I would like to do crafts. I am helped by tactile things that can help ground me in the moment.
9. Please tell me Cowboy jokes.

Things that may make things worse:

1. Please do not use my legal name as it is not my name.
2. Please do not use the pronouns, he/him, as they are inaccurate.
3. Please do not have a man engage with me.
4. Please do not block me in.
5. Please do not say, “Calm down.”

DIRECTIVES IF I AM HOSPITALIZED

A. Statement of My Preferences Regarding Treatment Facility

1. Preferred psychiatric hospitals

In the event my psychiatric condition is serious enough to require 24-hour care and I have no physical conditions that require immediate access to emergency medical care, I would prefer to receive care at the following hospitals:

FIRST:	Name:	Hospital A
	Address:	
	Phone Number:	
	Reason:	They helped me in the past.
SECOND:	Name:	Hospital B
	Address:	
	Phone Number:	
	Reason:	People I trust have recommended it.

2. I prefer **not** to receive care at the following psychiatric hospitals

FIRST:	Name:	Hospital C
	Address:	
	Phone Number:	
	Reason:	My wishes were not respected. They didn’t listen to me. My time in this hospital made me sick.

B. Statement of My Preferences Regarding Notification of Others

1. People who should be notified:

If I am inside a medical or mental health facility of any kind, whether public or private, including, but not limited to, emergency rooms, psychiatric hospitals, medical hospitals, psychiatric units or wings of medical hospitals, crisis stabilization units, county jails or Texas Department of Criminal Justice institutions, I direct hospital staff to notify the following individuals immediately by telephone. I waive my privacy rights under the Health Insurance Portability and Protection Act for the purpose of this notification only.

Name: Mary Smith
Relationship: Mother
Telephone: (555) 555-5555
Address:

Name:
Relationship:
Telephone:
Address:

If I am inside a medical or mental health facility of any kind, whether public or private, including, but not limited to, and whether public or private, emergency rooms, psychiatric hospitals, medical hospitals, psychiatric units or wings of medical hospitals, crisis stabilization units, county jails or Texas Department of Criminal Justice institutions, regardless of whether I have been appointed an attorney, I direct hospital staff to provide me with a telephone so that I may contact an attorney of my choice.

Any attorney who has been appointed to represent me or any attorney I retain must be provided a copy of this document.

C. The Identity of My Medical Power of Attorney

I have executed a Medical Power of Attorney. The Medical Power of Attorney should go into effect if I become incapable of giving consent to medical or mental health care treatment.

The contact information for my Medical Power of Attorney is: / and alternate Medical Power of Attorney are:

Name: [Agent's Name]
Relationship:
Address: [Agent's Address, City, State, Zip]
Phone Number: [(XXX) XXX-XXXX]

Alternate:
Name: [Alternate's Name]
Relationship:
Address: [Agent's Address, City, State, Zip]
Phone Number: [(XXX) XXX-XXXX]

D. Identity of My Next of Kin

Name: [Agent's Name]
Relationship:
Address: [Agent's Address, City, State, Zip]
Phone: [(XXX) XXX-XXXX]

Name: [Agent's Name]
Relationship:
Address: [Agent's Address, City, State, Zip]
Phone: [(XXX) XXX-XXXX]

E. Statement of My Preference Regarding Revocation or Termination of This Declaration for Mental Health Treatment

1. Revocation of My Declaration for Mental Health Treatment During a Period of Incapacity

In accordance with Texas Mental Health Code, CPRC § 137.010, my wish is that this mental health care directive may be revoked, suspended or terminated by me only at times that I have the capacity and competence to do so.

2. Notwithstanding the above, it is my wish that my agent or other decision-maker specifically ask me about my preferences before making a decision regarding mental health care and take the preferences I express here into account when making such a decision, even while I am incompetent or incapacitated.

F. Personal items I would like to have in the hospital.

If I have not been able to do so, I would very much appreciate X packing a bag with the following items:

1. Pants (3)
2. Shirts (3)
3. Underwear (3)
4. Socks (3)
5. Pajamas
6. Flip Flops
7. Toothpaste and Toothbrush
8. Comb
9. Mint tea
10. Fidget spinner

G. Household

Example: I would like for my sister, Sally Garcia, to pay my rent and bills. All the information about my rent and bills is in a red folder in the top drawer of the desk in the living room. Sally has a spare key.

Example: I would like for my sister, Sally Garcia, to take care of my cat and my plants. She has a spare key.

Example: I would like for my sister, Sally Garcia, to collect and review my mail and take care of anything that must be handled while I am in the hospital.

H. Finances

Example: I authorize my sister, Sally Garcia, to access any account in my name at any financial institution. I authorize my sister, Sally Garcia, to act on my behalf for any financial situations which may arise.

May need an additional legal document to give (limited time and limited powers) the person access/permission to handle the identified financial needs.

I. Employment

Example: I would like for my sister, Sara Jones, to call my supervisor, Mary Smith, at my place of employment at (999) 999-9999 to let her know I am in the hospital. If Mary Smith is no longer my supervisor, I would like for Sara to make sure to communicate directly with my current supervisor.

J. Education

Example: I would like for my brother, John Dominguez, to call disability services at my school and let them know that I am in the hospital and need to make arrangements for my studies. The disability services phone number is (444) 444-4444. Sofia Jones has helped me in the past.

Example: I would like for my sister, Sara Jones, to call the VA department at my school, the University of Texas at Arlington (333) 333-3333 and let them know that I am in the hospital. They will need the last four digits (1234) of my Social Security number and my last name. Sara's number is (210) 222-2222.

K. Probation

Example: I would like for my sister, Sally Garcia, to contact my community supervision officer, X, at (777) 777-7777, and let them know I am in the hospital. My sister, Sally Garcia, will ask the name of the person she notified and make a note of the name and time.

L. Attorney

Example: I would like for my sister, Sally Garcia, to contact my attorney, X, at (555) 555-5555, and let them know I am in the hospital.

SIGNATURE PAGE AND WITNESSES

This document must be signed in front of two witnesses or a Notary Public.

By signing here, I indicate that I understand the purpose and effect of this document and each of the parts therein.

________________________________ ________________________________
NAME Date

I declare under penalty of perjury that the principal's name has been represented to me by the principal, that the principal signed or acknowledged this declaration in my presence, that I believe the principal to be of sound mind, that the principal has affirmed that the principal is aware of the nature of the document and is signing it voluntarily and free from duress, that the principal requested that I serve as witness to the principal's execution of this document, and that I am not a provider of health or residential care to the principal, an employee of a provider of health or residential care to the principal, an operator of a community health care facility providing care to the principal, or an employee of an operator of a community health care facility providing care to the principal.

I declare that I am not related to the principal by blood, marriage, or adoption and that to the best of my knowledge I am not entitled to and do not have a claim against any part of the estate of the principal on the death of the principal under a will or by operation of law.

Dated at Bexar County, Texas this ________ day of________________________, 2021.

Witness Signatures:

________________________________ ________________________________
NAME Date

________________________________ ________________________________
NAME Date

OR

Notary Public
State of Texas
County of Bexar
This document was acknowledged before me on ______________________________ (date)
By _________________________________

____
(Signature of Notary)

____
(Date commission expires)

INDIVIDUALS WHO HAVE COPIES OF THIS DOCUMENT

I have given copies of this document to:

Name	Address or phone
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
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