Directiva anticipada de salud mental

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Una Directiva anticipada de salud mental puede ayudarle si padece una enfermedad mental que a veces afecta su capacidad de tomar decisiones sobre su atención médica. En este documento, también puede nombrar un apoderado en materia de salud mental y dar su consentimiento para tratamientos específicos por adelantado que una directiva general de atención médica y un poder notarial no pueden autorizar. (Formulario e instrucciones)

Form attached:
Instrucciones anticipadas de salud mental (NJP Planning 511 ES)

Reúna esta información antes de empezar:

- Medicamentos que toma (nombre, dosis, farmacia)
- Medicamentos a los que es alérgico o con los que ha tenido malas experiencias

- Datos de contacto de su apoderado (si lo tiene) y de sus posibles sustitutos

¿Qué es una Directiva anticipada de salud mental?

Es un formulario que usted utiliza para manifestar lo que quiere que ocurra si su enfermedad mental se vuelve tan grave que necesita ayuda de otras personas. Sirve de guía para su apoderado médico, amigos, familiares y proveedores de atención médica sobre qué tipos de atención de salud mental son más adecuados para usted. Puede hacerles saber qué tipo de cuidados necesita, y puede incluir medicamentos, tratamientos e incluso quién puede visitarle si está hospitalizado.

Su directiva puede incluir cualquier cosa que pueda ayudar a otros a saber cómo prestarle la atención que necesita cuando experimenta síntomas graves de su enfermedad mental, incluidos los siguientes ejemplos:

- Puede aprobar, rechazar o poner límites a **medicamentos** psiquiátricos.
- Puede aprobar, rechazar o poner límites a **tratamientos psiquiátricos**.
- Puede aprobar la **hospitalización** si sus síntomas se agravan.
- Puede decir quién puede y quién no puede **visitarle** si se encuentra en el hospital.
- Puede nombrar los **tipos de cuidados que quiere que el personal médico pruebe** antes de recurrir a medidas más drásticas, como la inmovilización.

¿Y si tengo un Poder notarial de atención médica?

Debe adjuntar una copia de su formulario de *Poder notarial* a su *Directiva anticipada de salud mental*.

> Un poder general para la atención médica **no puede autorizar** la hospitalización por problemas de salud mental ni la terapia electroconvulsiva (TEC). Si quiere que su apoderado pueda autorizar esas cosas, debe nombrar un apoderado en materia de salud mental. Puede hacerlo en su formulario de Directiva anticipada de salud mental. Para evitar confusiones, lo mejor es nombrar a la misma persona como apoderado en materia de salud mental que para la atención médica general.

Si no tiene un Poder notarial de atención médica, también debe llenar uno. Puede llenarlo por separado (blank) o al mismo tiempo que su Directiva anticipada de salud mental (blank) en WA Forms Online

> Piense detenidamente en quién quiere como apoderado (agente). Elija a alguien en quien confíe para que tome decisiones acordes con sus valores en materia de atención médica, incluso si esa persona, en su lugar, tomaría decisiones diferentes.

¿Puedo seguir tomando mis propias decisiones?

Conforme a la ley estatal, usted es capaz de tomar sus propias decisiones si no tiene tutor y ningún juez le ha declarado "incapacitado". Puede leer la ley estatal al respecto, incluyendo la definición legal de capacidad, en el Código Enmendado de Washington 71.32.020 (http://app.leg.wa.gov/RCW/default.aspx?cite=71.32.020).

También puede modificar o anular en cualquier momento su Directiva anticipada de salud mental. Puede hacerlo verbalmente o por escrito. Asegúrese de comunicárselo a sus proveedores de atención médica y a cualquier persona a la que haya otorgado un poder notarial.

¿Necesito que el documento esté notariado?

Siempre es mejor que firme su directiva ante un notario.

Si no encuentra un notario, puede firmar ante dos testigos. A continuación, una lista de personas que **no pueden ser** testigos de su firma:

- Alguien a quien usted haya otorgado un poder notarial de atención médica
- Su proveedor de atención médica
- Un propietario o empleado de cualquier centro en el que usted sea paciente o en el que viva
- Cualquier persona con quien tenga parentesco
- Cualquier persona con la que tenga una relación amorosa
- Cualquier persona que pueda beneficiarse económicamente de que usted reciba tratamiento de salud mental

¿Qué debo hacer después de firmar esta directiva?

Debe entregársela a todos los proveedores de atención médica que participen en su tratamiento de salud mental y a todos los agentes que haya nombrado en su directiva y Poder notarial.

Además, le recomendamos preguntar en su hospital local si pueden guardarla en sus archivos.

¿Es legal una Directiva anticipada de salud mental?

Sí. Una Directiva anticipada de salud mental es una directiva anticipada legal. Por lo general, los proveedores de atención médica están obligados legalmente a cumplir sus directivas anticipadas. La mejor manera de asegurarse de que se cumplan sus deseos es hablar con su equipo médico, su centro de atención, sus cuidadores y sus familiares acerca de *su* Directiva anticipada de salud mental.

Mental Health Advance Directive

My name is _____. My date of birth is _____.

I am a person with decision-making capacity. I voluntarily sign this directive so my choices about my mental health care will be known when I cannot make decisions for myself. If any part of this directive is invalid, the rest should be honored. I revoke any mental health care directives I have signed in the past.

1. **Start date.** This directive is effective (*check one*):

   [ ] Now.

   [ ] Only if I can't make decisions for myself (if I'm incapacitated).

   [ ] When these circumstances, symptoms, or behaviors occur:

   _____

   _____

   _____

2. **End date.** I want this directive to (*check one*):

   [ ] Remain in effect until revoked.

   [ ] Automatically end _____ years from the date it was created.

3. **Revocation.** I can cancel (revoke) this directive (*check one*):

   [ ] **Only when I can make decisions for myself (when I have capacity).** I understand this means I can't cancel this directive unless I have capacity. It means I may receive the medical care and medication listed in this directive even if I object at the time.

   [ ] **Even if I cannot make decisions for myself (if I'm incapacitated).** I understand this means I can cancel this directive at any time. This means I may not get the medical care and medication listed in this directive when I am incapacitated.

4. **My care needs: What works for me.** I want my providers and my mental health care agent to know this information (*check all that apply*):

   [ ] I've been diagnosed with the following mental health and/or physical diagnoses:

   _____

   _____

   _____

   [ ] Here is the best treatment method for my illness (*give a general overview of what works best for you*):

   _____

   _____

   _____

   _____

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[ ] I take these medications or supplements:

_____

_____

[ ] I have a history of drug or alcohol abuse. Here are my preferences and treatment options around medication management related to drug or alcohol abuse:

_____

_____

My preferences and instructions

5. **Medical providers.** I want these medical providers to be involved in my mental health care decisions:

_____

_____

6. **Medications** (*check all that apply*)

[ ] I have allergies to or severe side effects from these medications:

_____

_____

[ ] I consent to these medications for mental health treatment:

_____

_____

[ ] I **do not** consent to these medications for mental health treatment:

_____

_____

[ ] I will take the medications excluded above if the following side effects can be eliminated by adjusting the dose or other means:

_____

_____

[ ] I will try any other medications for mental health treatment recommended by (*check one*)

[ ] any medical provider

[ ] these medical providers only:

_____

[ ] I **don't** want to try any other medications for mental health treatment.

[ ] Other medication preferences or instructions:

_____

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7. Alternative interventions

I want these interventions before psychiatric hospitalization is considered:

[ ] Call someone or have someone call me.

Name: _____ Phone/Text: _____

Email: _____

[ ] Stay overnight with someone.

Name: _____ Phone/Text: _____

Email: _____

[ ] Connect me with a peer counselor.

[ ] Connect me with a mental health care provider.

[ ] Go to a crisis triage center or emergency room.

Preferred location (if any): _____

[ ] Stay overnight at a crisis respite (temporary) bed.

[ ] See a medical provider for help with psychiatric medications.

[ ] Other: _____

8. Psychiatric Hospitalization

If you are worried you'll refuse to stay at a psychiatric hospital when your medical provider/s recommend it, you can consent to hospitalization in advance. If you don't consent, someone would have to get a court order for your involuntary commitment to a psychiatric hospital.

Important! By consenting to inpatient mental health treatment now, while you are well, you may get treatment sooner if you decompensate.

Check one (sign if consenting):

[ ] **I consent** to voluntary admission to inpatient mental health treatment for (*up to 14*) _____ days (*check one*):

[ ] With no limits.

[ ] With these limits (*check all that apply*):

[ ] My health care providers decide it is appropriate.

[ ] My mental health care agent (if I have one) decides it is appropriate.

[ ] Under these circumstances (specify symptoms, behaviors, or circumstances that indicate the need for hospitalization):

_____

_____

▶ _____

My signature (*in front of a notary or witnesses*)

[ ] **I do not consent** to inpatient mental health treatment.

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9. Psychiatric hospital preferences and instructions

[ ] If I need hospitalization, I prefer these hospitals:

_____

[ ] If I need hospitalization, I **do not** consent to be admitted to these hospitals:

_____

[ ] **Alternative programs or facilities.** I prefer to get treatment in mental health programs or facilities that are alternatives to psychiatric hospitals, if possible.

[ ] No preference.

10. Seclusion, restraint, and emergency medications

If my behavior requires seclusion, physical restraint, and/or emergency use of medication, I prefer these interventions in the order I've numbered them (*choose "1" for try this first, "2" for try this second, and so on*):

___ Seclusion

___ Seclusion and physical restraint (combined)

___ Medication by injection

___ Medication in pill or liquid form

If emergency medication is required, follow my preferences in section 6 (Medication) to the extent possible.

Interventions. I want the interventions below tried before use of seclusion, restraint or emergency medication is considered (*check all that apply*):

[ ] "Talk me down" one-on-one

[ ] More medication from my list of preferred medications above

[ ] Time out/privacy

[ ] Shift my attention to something else

[ ] Set firm limits on my behavior

[ ] Help me to discuss/vent feelings

[ ] Decrease stimulation

[ ] Offer to have neutral person settle dispute

[ ] Show of authority/force

[ ] Other: _____

_____

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11. Electroconvulsive Therapy (ECT)

Electroconvulsive therapy (ECT) is a medical treatment that involves sending an electric current through the brain to induce a brief seizure, or surge of electrical activity. The goal is to relieve severe symptoms of certain mental health conditions, such as severe depression or bipolar disorder that have not responded to other treatments.

You can consent to ECT in advance. If you don't consent, a medical provider would have to get a court order authorizing involuntary treatment.

Important! By consenting to ECT now, while you are well, you may get treatment sooner if you decompensate.

Check one (sign if consenting):

[ ] **I consent** to electroconvulsive therapy (*check one*):

[ ] With no limits.

[ ] With these limits (*check all that apply*):

[ ] My health care providers decide it is appropriate.

[ ] My mental health care agent (if I have one) decides it is appropriate.

[ ] Under these conditions only (*specify symptoms, behaviors, or circumstances that indicate the need for electroconvulsive therapy*):

_____

_____

_____

▶ _____

My signature (*in front of a notary or witnesses*)

[ ] **I do not consent** to electroconvulsive therapy.

12. Excluded visitors

If I've been hospitalized, these people may **not** visit me:

Name: _____

Name: _____

Name: _____

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13. Durable Power of Attorney for Mental Health Care (optional)

> ***Important!*** A general power of attorney for health care can't authorize mental health hospitalization or electroconvulsive therapy (ECT). If you want your power of attorney to be able to consent to those things, you must complete the power of attorney for mental health care section below. You should appoint the same person as your agent for mental health care as for general health care to avoid confusion.

[ ] I am **not** appointing a power of attorney **for mental health care**.

[ ] I am appointing a power of attorney **for mental health care** as follows. I revoke (cancel) any other power of attorney for mental health care documents I signed in the past.

a. Agent. I choose (*name*): _____ as my agent with full authority to manage my mental health care.

[ ] **Alternate.** If the agent named above is unable or unwilling to act, I choose (*name*): _____ as my agent with full authority to manage my mental health care.

[ ] **2nd Alternate.** If both the agent and alternate named above are unable or unwilling to act, I choose (*name*): _____ as my agent with full authority to manage my mental health care.

b. Spouse or partner.

[ ] Does not apply. I didn't name my spouse or partner as an agent or alternate.

[ ] One of the agents or alternates named above is my spouse or domestic partner. If we divorce or legally separate (*check one*):

[ ] Their authority to act as my agent is revoked.

[ ] They will continue to have authority to act as my agent.

c. My Rights. I keep the right to make mental health care decisions for myself if I am capable.

d. Durable. My agent can use this power of attorney to manage my affairs even if I become sick or injured and cannot make decisions for myself. My disability will not affect this power of attorney.

e. Revocation. I understand that I may revoke this power of attorney at any time by giving written notice of revocation to my agent.

f. Powers. My agent shall have full power and authority to make mental health treatment decisions on my behalf. This authority includes the right to make decisions consistent with any instructions and/or limitations in this directive. If my agent does not know my wishes, I authorize my agent to make the decision that my agent determines is in my best interest.

g. Nomination of Guardian. I nominate my agent as my guardian for consideration by the court if guardianship proceedings become necessary.

h. HIPAA Release. I authorize my healthcare providers to release all information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to my agent.

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14. Other documents. I have attached the following other documents to this directive:

[ ] Durable Power of Attorney for Health Care (**not** mental health)

[ ] Durable Power of Attorney for Finances

[ ] Health Care Directive ("Living Will")

[ ] Other (*Examples: Crisis Plan, Wellness and Recovery Plan*):

_____

_____

15. Notifying others and caring for my personal affairs. If I'm admitted to a mental health facility, please follow my instructions on the attachment if possible. I understand the instructions on the attachment are not my medical providers' responsibility.

16. Acknowledgement. I understand the purpose and effect of this Mental Health Advance Directive. I understand consent to treatment or admission in this Mental Health Advance Directive constitutes my informed consent. I am signing of my own free will for the purposes stated in this document.

▶ _____ _____

My signature (*in front of a notary or witnesses*) Date

Notarization (preferred)

State of Washington
County of _____

This document was acknowledged before me on (date) _____

by (name) _____.

▶ _____

Signature of Notary

Notary Public for the State of Washington.

My commission expires _____.

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Statement of Witnesses (only if you cannot find a notary)

On (*date*): _____, (*name*): _____ signed this Advance Directive in my presence. This person is personally known to me or provided proof of identity. I believe they are able to make health care decisions, to understand this document, and to have signed it voluntarily. They do not appear to be acting under duress, undue influence, or fraud.

I am **not**:

- A person designated to make medical decisions for them
- A health care provider or professional directly involved in their care at the time the directive is made
- An owner, operator, employee, or relative of an owner or operator of a health care facility or long-term care facility where they are a patient or resident
- A person related by blood, marriage, or adoption to them
- In a dating relationship with them (see RCW 7.105.010)
- A minor or incapacitated person
- A person who would benefit financially if they undergo mental health treatment

Witness 1

▶ _____

Signature

Print Name: _____

Address: _____

_____

Phone: _____

Witness 2

▶ _____

Signature

Print Name: _____

Address: _____

_____

Phone: _____

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Mental Health Advance Directive
Attachment: Contact info, who to notify, personal affairs

My information

My name _____

My date of birth _____

My phone number _____

My email address _____

My mailing address _____

_____

My primary care medical provider

_____

Power of attorney

[ ] I have a **Durable Power of Attorney for Mental Health Care** that lets someone else (my "agent") make health care decisions for me if I'm not able.

My mental health care agent (if any)

Name _____

Relationship to me (Examples: friend, partner, spouse, sister, etc.)

_____

Phone _____

Email _____

My alternate mental health care agent (if any)

Name _____

Relationship to me (Examples: friend, partner, spouse, sister, etc.)

_____

Phone _____

Email _____

My 2nd alternate mental health care agent (if any)

Name _____

Relationship to me (Examples: friend, partner, spouse, sister, etc.)

_____

Phone _____

Email _____

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Who to notify

If I'm admitted to a mental health facility, please notify these people as soon as possible:

Name: _____

Phone/Text: _____ Email: _____

Name: _____

Phone/Text: _____ Email: _____

Name: _____

Phone/Text: _____ Email: _____

Personal affairs

If I'm admitted to a mental health facility, these are my instructions about my personal affairs:

Dependents: _____

_____

_____

Pets: _____

_____

_____

Cars: _____

_____

_____

Household: _____

_____

_____

Other: _____

_____

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