Full Name (Last, First, Middle): _____

Address: _____

City/State/Zip: _____

Date of Birth (mm/dd/yyyy): _____/_____/_____

WV e-Directive Registry Opt In HTTPS://WVENDOFLIFE.ORG/REGISTRY

The WV e-Directive Registry makes your forms immediately available to your health care providers in emergencies. If you agree to have this form and any other submitted forms included in the WV e-Directive registry and released to treating health care providers, please mark below.

_____ _____

YES, I OPT IN NO, I DON'T OPT IN

STATE OF WEST VIRGINIA
MENTAL HEALTH ADVANCE DIRECTIVE

The Types of Treatment I Do and Do Not Want and The Person I want to Make Mental Health Treatment Decisions for Me When I Can't Make Them for Myself

Dated: _____, 20_____

I am giving the following DIRECTIVES (instructions) about treatment that I do and do not want (NOTE: the below are suggestions of things about which you might want to give directives; you may give directives about other types of treatment in addition to or instead of those below):

- the medications I consent to (types and dosage),
- the medications to which I do not give consent (allergies or side effects),
- instructions about short-term inpatient treatment,
- a physician or mental health therapist whom I would like to treat me,
- a facility where I would like to receive treatment,
- instructions about transport to a provider or facility,
- instructions about electroconvulsive treatment (ECT) shock therapy,
- persons to be notified of my mental health treatment,
- persons to be allowed to visit me, and
- instructions about alternative outpatient treatments I would like.

My failure to provide directives does not mean that I want or refuse certain treatments.

Directive with Regard to Revocation – changing my mind
(initial only one of the boxes below)

☐ My wish is that, in accordance with state law, this mental health advance directive may be revoked by me at any time.

☐ My wish is that I may revoke (change my mind about) this mental health advance directive only at times that I have the capacity to make my own mental health care decisions. I understand that I am choosing to give up the right to revoke my mental health advance directive whenever I do not have decision-making capacity and that I will regain that right whenever I recover decision-making capacity.

Crisis Response (completion optional)

The following signs and symptoms may indicate that I am in a mental health crisis:

_____

_____

_____

_____

_____

I request the following interventions/activities in a mental health crisis regardless of setting (community, outpatient or inpatient) which may reduce my symptoms, make me more comfortable, and keep me safe:

_____

_____

_____

_____

_____

In a psychiatric emergency, PLEASE AVOID the following interventions that make me feel worse:

_____

_____

_____

_____

_____

Are you in recovery for, or do you have a substance use disorder (addiction)?_____

If yes, which substances are you most likely to use when your substance disorder is active?

_____

_____

_____

_____

_____

Temporary Custody of Dependents (only applies when I lack the capacity to make my own mental health care decisions and choose to say whom I would want to watch my dependents)

I have the following dependent(s), which may include children, support service animal, pets, etc.:

_____

_____

_____

_____

_____

In the event that I am unable to care for my dependent(s), I direct that the following person have temporary custody of my dependent(s) (only applies when I lack capacity):

Name: _____

Address: _____

_____

Phone Numbers: _____

Dependent(s): _____

For the following reason(s): _____

_____

_____

_____

_____

_____

Name: _____

Address: _____

_____

Phone Numbers: _____

Dependent(s): _____

For the following reason(s): _____
_____

_____

_____

_____

_____

Person(s) to be notified at the time of discharge from a mental health care facility (completion optional)

Name(s): _____

Address(es):_____

_____

Phone Number(s):_____

The Person I Want to Make Health Care Decisions For Me When I Can't Make Them for Myself

I, _____,
(Insert your name and address)

hereby appoint as my representative to act on my behalf to give, withhold, or withdraw informed consent to mental health care decisions in the event that I am not able to do so myself.

The person I choose as my mental health care representative is (One person):

_____

_____

(Insert the name, address, area code, and telephone number of the person you wish to designate as your representative. Please insert only one name.)

The person I choose as my successor mental health representative is (One person):
If my representative is unable, unwilling, or disqualified to serve, then I appoint

_____

_____

(Insert the name, address, area code, and telephone number of the person you wish to designate as your successor representative. Please insert only one name.)

☐ I do not wish to appoint a mental health care representative. *(Mark this box to select this choice)*

This appointment shall be for the purpose of mental health care decisions. Mental health care means treatment of "mental illness" as defined at West Virginia Code §27-1-2 with psychoactive medication, admission to and retention in a mental health care facility, electroconvulsive treatment and outpatient services. The representative appointed by this document is specifically authorized to be granted access to my medical records and other health information and to act on my behalf to consent to, refuse or withdraw any and all mental health care if my representative determines that I, if able to do so, would consent to, refuse or withdraw such treatment. The authority of the mental health care representative ceases when I have regained capacity to make mental health care decisions.

I appoint this representative because I believe this person understands my wishes and values and will make the mental health care decisions that I would make if I were able to do so, and because I also believe that this person will act in my best interest when my wishes are unknown. It is my intent that my family, my physician and all legal authorities be bound by the decisions that are made by the representative appointed by this document, and it is my intent that these decisions should not be the subject of review by any health care provider or administrative or judicial agency.

It is my intent that this document be legally binding and effective and that this document be taken as a formal statement of my desire concerning the method by which any mental health care decision should be made on my behalf during any period when I am unable to make such decisions.

In exercising the authority under this mental health advance directive, my representative shall act consistently with my special directives as stated in this advance directive.

THIS MENTAL HEALTH ADVANCE DIRECTIVE SHALL BECOME EFFECTIVE ONLY UPON MY INCAPACITY TO GIVE, WITHHOLD OR WITHDRAW INFORMED CONSENT TO MY OWN MENTAL

HEALTH CARE. INCAPACITY IS TO BE DETERMINED BY A QUALIFIED PHYSICIAN AND A SECOND QUALIFIED PHYSICIAN OR QUALIFIED PSYCHOLOGIST.

_____ DATE _____

Signature of the Principal *(Sign your name)*

_____

Address of the Principal *(Write your full address)*

I did not sign the principal's signature above. I am at least 18 years of age and am not related to the principal by blood or marriage. I am not entitled to any portion of the estate of the principal or to the best of my knowledge under any will of the principal or codicil thereto, nor legally responsible for the costs of the principal's medical or other care. I am not the principal's attending physician, nor am I the representative or successor representative of the principal.

Witness _____ DATE _____

Witness _____ DATE _____

STATE OF _____

COUNTY OF _____

I, _____, a Notary Public of said County, do certify that_____, as principal, and _____ and _____, as witnesses, whose names are signed to the writing above bearing date on the _____ day of _____, 20_____, have this day acknowledged the same before me.

Given under my hand this ____ day of _____, 20___.

My commission expires:_____

_____

Signature of Notary Public

Insert Notary Stamp Above