



## **ADVANCE HEALTH CARE DIRECTIVES**

### **FOR PLANNING MENTAL HEALTH CARE**

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## ABOUT THIS GUIDE

An advance directive is a tool which you can use to guide your future medical care. It is a legal document which, when properly filled out and signed, instructs your health care provider on how to treat you according to your preferences. Your advance directive can also name a person you trust as your decision-maker for your health care if, for some reason, you are incapable of making those decisions yourself.

There are two laws in Maine that cover advance directives: “The Uniform Health Care Decisions Act” and the “Medical Treatment of Psychotic Disorders Act”. This manual is designed for using the “Uniform Health Care Decisions Act”. This is a law that gives individuals more choices and has more protections.

DRM developed this guide as a resource that individuals can use to understand, write and execute an advance directive under Maine state law. We hope this guide will help you:

- ☆ Learn more about an advance directive for mental health care.
- ☆ Decide whether you want one.
- ☆ Develop an advance directive for mental health care.
- ☆ Know what questions to ask if you have someone help you write one.
- ☆ Use your advance directive for mental health care.
- ☆ Understand the limits to an advance directive.

This guide is intended to provide a simple yet informative overview of advance directives. It is not a substitute for legal advice. If you have questions or would like assistance with specific issues, please contact Disability Rights Maine.



# HOW TO USE THIS GUIDE

This guide is divided into three parts, each one designed to help you navigate the advance directive system. These documents can be difficult to understand, so as you decide whether an advance directive is right for you, refer back to this guide. It can help explain legal terms and requirements.

The three parts to this guide are:

(1) A blank advance directive form

- ☆ This is the form that you will need to fill out to have a working advance directive.
- ☆ The attached form can be used as your advance directive.

(2) An advance directive form followed by questions and answers

- ☆ The Q&A is meant to define some of the confusing terms within the advance directive form and to describe the potential impact that your advance directive may have on your future medical care.
- ☆ The form is broken down into multiple sections, with short Q&As immediately following each section.
- ☆ If you have questions about the content or consequences of something in the advance directive form, refer to this section. It may not answer all of your questions, but the Q&A should cover most of the basics.

(3) Section 803 of Maine's advance directive statute

- ☆ This guide only contains one section (Section 803) of the statute regarding advanced healthcare directives. It is provided for informational purposes only and should not be relied on as the full text of the statute governing advanced healthcare directives.
- ☆ The information provided in this guide comes from the full statute, *18-C M.R.S. §5-801 et seq.*



**SECTION I: BLANK ADVANCE DIRECTIVE  
FOR MENTAL HEALTH CARE FORM**



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**FORM 1: ADVANCE DIRECTIVE, INCLUDES OPTIONS FOR  
BOTH POWER OF ATTORNEY AND INSTRUCTIONS**



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# ADVANCE HEALTH CARE DIRECTIVE

## For Mental Health Care

Under the Uniform Health Care Decisions Act  
*18-C M.R.S. §5-801 et seq.*

I, \_\_\_\_\_, currently of \_\_\_\_\_,  
Name Street address City

Maine, whose birth date is \_\_\_\_\_, execute this Advance Health Care Directive and Power of Attorney for health care so that I might obtain mental health care and treatment.

### PART I. POWER OF ATTORNEY FOR HEALTH CARE

*(Complete this part only if you are appointing an agent to make decisions for you.)*

(1) DESIGNATION OF AGENT: I, \_\_\_\_\_, designate the following individual as my agent to make mental health care decisions for me:

\_\_\_\_\_  
(Name of Individual)

\_\_\_\_\_  
(Home Phone) (Work Phone)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(City) (State) (Zip)

(2) DESIGNATION OF ALTERNATIVE AGENT (*OPTIONAL*): If I revoke this agent's authority or if my agent is not willing, able or reasonably available to make mental health care decisions for me, I designate as my first alternate agent:

\_\_\_\_\_  
(Name of Individual)

\_\_\_\_\_  
(Home Phone) (Work Phone)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(City) (State) (Zip)



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- (3) AGENT AND ALTERNATIVE AGENT UNAVAILABLE: If I revoke the authority of my agent and first alternate agent, if I have named one, or if neither my agent or alternate, if I have named one, is willing, able or reasonably available to make health care decisions for me, the instructions in this health care directive are nevertheless to be followed without need for the express authorization of an agent.

Yes \_\_\_\_\_ No \_\_\_\_\_

- (4) AGENT'S AUTHORITY: My agent is authorized to make all health care decisions, consistent with the instructions and limitations as set out in this document, that in my agent's judgment relate to psychiatric, psychological and emotional care and treatment, including the right to consent, withhold consent or withdraw consent to any test, procedure, program of medications or any form of mental health care and treatment and to select or discharge any mental health care providers or institutions.
- (5) AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what the agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

**PART II: WHEN ADVANCE DIRECTIVE BECOMES EFFECTIVE** *(This part needs to be completed whether you are appointing an agent, giving instructions or doing both.)*

- (6) WHEN ADVANCE DIRECTIVE (INCLUDING AGENT'S AUTHORITY, IF ONE APPOINTED) BECOMES EFFECTIVE: This advance directive becomes effective when:  
*(Indicate the Applicable Options)*

\_\_\_\_\_ Immediately *(this option is available only if you have appointed an agent)*

\_\_\_\_\_ My primary physician, or, if I should be in an emergency room or in a treatment setting, the attending physician, determines that I am unable to make my own health care decisions.

\_\_\_\_\_ My primary physician, or, if I should be in an emergency room or in a treatment setting, the attending physician, determines that I meet involuntary hospitalization standards.

\_\_\_\_\_ My primary physician, or, if I should be in an emergency room or in a treatment setting, the attending physician, determines that if I do not receive psychiatric hospitalization or the treatment as set out in this instrument my condition will quickly deteriorate such that I would soon meet the standard for involuntary hospitalization.



\_\_\_\_ Other: *(Describe)* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The above options require a second physician's opinion.

Yes \_\_\_\_\_ No \_\_\_\_\_

I waive the 2<sup>nd</sup> opinion requirement if another physician is not available.

Yes \_\_\_\_\_ No \_\_\_\_\_

(If I require a second opinion and do not waive the requirement should no second physician be available, I understand that my advance directive may not become effective.)

(7) **NOMINATION OF GUARDIAN (OPTIONAL):** If a guardian of my person is to be appointed by a court, I nominate the following individual to be appointed as my guardian.

\_\_\_\_\_  
(Name of Individual)

\_\_\_\_\_  
(Home Phone)

\_\_\_\_\_  
(Work Phone)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(City)

\_\_\_\_\_  
(State)

\_\_\_\_\_  
(Zip)

**PART III: INSTRUCTIONS FOR HEALTH CARE**

*(Optional if you have appointed an agent. If giving instructions, you can choose those specific areas you wish to address and can add additional areas.)*

I request that I be provided the following treatment:

I. Alternatives to Hospitalization

In the event my condition becomes serious enough that I am found to need 24 hour care, I prefer to avoid hospitalization, and request that the following services be explored first.

\_\_\_\_ Crisis Respite Services. I prefer to receive the services at the following agencies:

\_\_\_\_\_  
(Names of Agencies if You Have Preferences)



\_\_\_\_\_ In-Home Services. I prefer to receive the following services: \_\_\_\_\_

\_\_\_\_\_  
(Names of Agencies if You Have Preferences & Description of Services)

\_\_\_\_\_ Other Services: (*Describe*) \_\_\_\_\_

My reasons for wanting these services as alternatives to hospitalization are as follows:

(*Optional, but recommended*) \_\_\_\_\_

II. Psychiatric Hospitalization

In the event that psychiatric hospitalization is deemed the only suitable alternative, I direct that it be sought at the following hospitals in the following order of priority:

\_\_\_\_\_  
Name of Hospital

\_\_\_\_\_  
Name of Hospital

\_\_\_\_\_  
Name of Hospital

\_\_\_\_\_  
Name of Hospital

This directive may operate as my informed consent to admission as a voluntary patient to the above listed hospitals.

This consent shall operate even if I pose any verbal objections at the time.

Yes \_\_\_\_\_ No \_\_\_\_\_



If none of the above hospitals have available beds, this directive may operate as my informed consent to admission to any other hospital as follows: *(Select One)*

\_\_\_\_\_ To any other hospital, provided I do not object at the time.

\_\_\_\_\_ To any other hospital, even if I am objecting at the time, *except for the following listed hospitals:*

\_\_\_\_\_  
Name of Hospital to Which My Consent is *Not* Given

\_\_\_\_\_  
Name of Hospital to Which My Consent is *Not* Given

\_\_\_\_\_  
Name of Hospital to Which My Consent is *Not* Given

My reasons for wanting these psychiatric hospitalization options are as follows:

*(Optional, but recommended)* \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If I am to be transported to a psychiatric hospital as an involuntary patient, I request that I be transported by the following means:

\_\_\_\_\_ Ambulance

\_\_\_\_\_ Sheriff or police vehicle. (I understand that by requesting this service I am waiving any claims or rights I may have under law to be transported in a medically equipped vehicle in the company of emergency medical technicians or other medically trained personnel.)

Other notes regarding transportation and my reasons for requesting transportation by this means are as follows: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



III. Medications

\_\_\_\_\_ I consent and my agent, if appointed, is authorized to consent to the administration of medications as follows:

Medication	Dosage Limits, If Any	Only Orally (If Checked)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

\_\_\_\_\_ All medications as prescribed by my primary physician, except as may be limited below.

\_\_\_\_\_ All medications as authorized by my agent, if appointed, except as may be limited below.

\_\_\_\_\_ I do not authorize and my agent, if appointed, may not consent to the following medications:

Medications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

My reasons for not consenting to the above medications are as follows:

(Optional, but recommended) \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ If any action can be taken to eliminate my above stated concerns regarding the excluded medications, my agent, if appointed, is authorized to consent to their administration provided such additional action is taken to accommodate my stated concerns.

\_\_\_\_\_ Other instructions with regard to medications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



IV. Emergency Interventions While in a Hospital

I understand that while I am in a psychiatric facility certain interventions may be authorized in an emergency should I be deemed to be imminently dangerous to myself or others.

I believe such an emergency can be avoided if I am treated in the following way: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If an emergency nevertheless arises, I prefer emergency interventions be implemented as follows: *(State preferences with regard to the use of seclusion, restraint, offer of oral medications, medications by injection, etc.):*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

V. Other Treatment While in a Hospital

I have responded favorably to the following treatment in a hospital setting, and request that these treatment options be offered.

Describe treatment options (family therapy, for example): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



VI. Electroconvulsive Therapy (ECT)

\_\_\_\_\_ I do not consent and my agent is not authorized to consent to the administration of ECT.

\_\_\_\_\_ I consent to the administration of ECT as prescribed by my primary physician, except as may be limited below.

\_\_\_\_\_ I consent to the administration of ECT as authorized by my agent, except as may be limited below.

\_\_\_\_\_ Limitations upon consent to the administration of ECT:

\_\_\_\_\_ My consent is limited to \_\_\_\_\_ number of treatments.

\_\_\_\_\_ Consent may not be sought from my agent, if one is appointed, until he/she/they has/have had \_\_\_\_\_ days to consider the risks and benefits of the treatment.

\_\_\_\_\_ My consent is otherwise limited as follows: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

My reasons for consenting or refusing ECT as set out above, are as follows:

*(Optional, but recommended)* \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ I direct that Disability Rights Maine (Phone: 800.452.1948 or Fax: 207.621.1419) be informed of any ECT treatment that I am to receive before I am to receive it and with enough advance notice so that DRM may contact me prior to the administration of any ECT treatment.

VII. Notices

If I am admitted to a facility, I request that the following individuals be notified immediately:

\_\_\_\_\_  
(Name of Individual)

\_\_\_\_\_  
(Home Phone)

\_\_\_\_\_  
(Work Phone)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(City)

\_\_\_\_\_  
(State)

\_\_\_\_\_  
(Zip)



\_\_\_\_\_  
(Name of Individual)

\_\_\_\_\_  
(Home Phone)

\_\_\_\_\_  
(Work Phone)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(City)

\_\_\_\_\_  
(State)

\_\_\_\_\_  
(Zip)

VIII. Child Care Arrangements

If I am to be admitted to residential care or to a hospital, or I am otherwise unable to care for my children, and I have not made prior child care arrangements, I authorize my agent to make those arrangements. If my agent or alternative is not available, I request that the following individual be contacted to care for my children temporarily:

\_\_\_\_\_  
(Name of Individual)

\_\_\_\_\_  
(Home Phone)

\_\_\_\_\_  
(Work Phone)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(City)

\_\_\_\_\_  
(State)

\_\_\_\_\_  
(Zip)

IX. Other Instructions

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**PART IV: PRIMARY PHYSICIAN**

I designate the following as my primary physician, for the purposes of this directive:

\_\_\_\_\_  
(Name of Physician)

\_\_\_\_\_  
(Phone Number)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(City) (State) (Zip Code)

**A COPY OF THIS FORM HAS THE SAME EFFECT AS THE ORIGINAL**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Name

\_\_\_\_\_  
Witness Name

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Witness Address

\_\_\_\_\_  
Witness Address

\_\_\_\_\_  
City State Zip Code

\_\_\_\_\_  
City State Zip Code

Dated: \_\_\_\_\_

Dated: \_\_\_\_\_



**FORM 2: CERTIFICATE OF CAPACITY**



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## CERTIFICATE OF CAPACITY

I, \_\_\_\_\_, being a licensed \_\_\_\_\_  
Name Physician or Psychologist

state that I know \_\_\_\_\_, and, as of the date of this statement, believe him/her/they to have capacity to execute a health care advance directive in that s/he understands the following:

His/her/their diagnosis;

Significant benefits, risks and alternatives to various treatment options; and

The consequences of not accepting recommended treatment.

I further believe that \_\_\_\_\_ can make and communicate a health care decision and he/she/they understands the consequences of naming someone else to make health care decisions under a power of attorney.

\_\_\_\_\_  
Signature

Dated: \_\_\_\_\_



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### **FORM 3: WALLET CARDS**

You may want to use one of the wallet cards on the following pages.

- ☆ Cut out the card you want to use, fold it in half and keep it in your wallet.
- ☆ Use the first card if you have a power of attorney.
- ☆ Use the second card if you only have instructions.



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**CARD FOR USE WITH HEALTH CARE POWER OF ATTORNEY:  
WITH OR WITHOUT INSTRUCTIONS**

**NOTICE TO MENTAL HEALTH  
PROVIDERS**

I have an advance directive for mental health care as allowed by  
Maine law 18-C M.R.S. §5-801 et seq. A copy is located at:

\_\_\_\_\_  
\_\_\_\_\_

Please obtain a copy of my directive and follow any instructions  
I have included.

I appointed \_\_\_\_\_ as my  
agent to make decisions for me. My agent can be reached at the  
following numbers.

Day: \_\_\_\_\_ Night: \_\_\_\_\_

Please contact my agent immediately if I am deemed in need of  
mental health care and deemed unable to make decisions  
myself.

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_



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**CARD FOR USE WITH HEALTH CARE ADVANCE DIRECTIVE:  
WITHOUT A POWER OF ATTORNEY**

**NOTICE TO MENTAL HEALTH  
PROVIDERS**

I have an advance directive for mental health care as allowed by  
Maine law 18-C M.R.S. §5-801 et seq. A copy is located at:

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---

---

Please obtain a copy of my directive and follow the instructions I  
have included for care.

I have included instructions in it for mental health care that I  
have consented to receive should I be deemed unable to make  
decisions for myself.

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_



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## **SECTION II: QUESTIONS & ANSWERS**



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**ADVANCE HEALTH CARE DIRECTIVE**  
**For Mental Health Care**

I, \_\_\_\_\_, currently of \_\_\_\_\_, \_\_\_\_\_,  
Name Street address City

Maine, whose birth date is \_\_\_\_\_, execute this Advance Health Care Directive and Power of Attorney for health care so that I might obtain mental health care and treatment.

**PART I. POWER OF ATTORNEY FOR HEALTH CARE**

*(Complete this part only if you are appointing an agent to make decisions for you.)*

(1) DESIGNATION OF AGENT: I, \_\_\_\_\_, designate the following individual as my agent to make mental health care decisions for me:

\_\_\_\_\_  
(Name of Individual) (Home Phone) (Work Phone)

\_\_\_\_\_  
(Address) (City) (State) (Zip)

(2) DESIGNATION OF ALTERNATIVE AGENT (*OPTIONAL*): If I revoke this agent's authority or if my agent is not willing, able or reasonably available to make mental health care decisions for me, I designate as my first alternate agent:

\_\_\_\_\_  
(Name of Individual) (Home Phone) (Work Phone)

\_\_\_\_\_  
(Address) (City) (State) (Zip)

(3) AGENT AND ALTERNATIVE AGENT UNAVAILABLE: If I revoke the authority of my agent and first alternate agent, if I have named one, or if neither my agent or alternate, if I have named one, is willing, able or reasonably available to make health care decisions for me, the instructions in this health care directive are nevertheless to be followed without need for the express authorization of an agent.

Yes \_\_\_\_\_ No \_\_\_\_\_



(4) **AGENT’S AUTHORITY:** My agent is authorized to make all health care decisions, consistent with the instructions and limitations as set out in this document, that in my agent’s judgment relate to psychiatric, psychological and emotional care and treatment, including the right to consent, withhold consent or withdraw consent to any test, procedure, program of medications or any form of mental health care and treatment and to select or discharge any mental health care providers or institutions.

(5) **AGENT’S OBLIGATION:** My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what the agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

**Q: What does “power of attorney for health care” mean?**

A: You are giving someone the power to make health care decisions for you without your input. If you lack capacity, the doctor will follow those choices, **even if you do not agree** with them at that moment.

**Q: What does “capacity” mean?**

A: Capacity means your ability to make decisions about your health care. Doctors make a decision on your capacity based on your ability to understand what they believe are the pros and cons of your treatment, other types of treatment, and your ability to communicate that decision to your doctor. A doctor must decide when you have regained capacity.

**Q: What is an “agent”?**

A: The person you choose to make your health care decisions is your agent. You name your agent in the advance directive. This should be someone who knows you well and that you trust.

**Q: Why would I give someone power of attorney for health care?**

A: Power of attorney for health care puts your health care decisions in the hands of someone you trust, when you cannot make them yourself. If you are in psychiatric crisis, doctors can say that you lack capacity to make your own health care decisions. If that happens, doctors will not let you decide how you are treated and will likely force treatment on you. In that case, it is helpful to have someone who you trust to make those decisions for you, based on what you have earlier communicated as your desired choices.



**PART II: WHEN ADVANCE DIRECTIVE BECOMES EFFECTIVE** *(This part needs to be completed whether you are appointing an agent, giving instructions or doing both.)*

(6) WHEN ADVANCE DIRECTIVE (INCLUDING AGENT’S AUTHORITY, IF ONE APPOINTED) BECOMES EFFECTIVE: This advance directive becomes effective when:  
*(Indicate the Applicable Options)*

\_\_\_\_\_ Immediately *(this option is available only if you have appointed an agent)*

\_\_\_\_\_ My primary physician, or, if I should be in an emergency room or in a treatment setting, the attending physician, determines that I am unable to make my own health care decisions.

\_\_\_\_\_ My primary physician, or, if I should be in an emergency room or in a treatment setting, the attending physician, determines that I meet involuntary hospitalization standards.

\_\_\_\_\_ My primary physician, or, if I should be in an emergency room or in a treatment setting, the attending physician, determines that if I do not receive psychiatric hospitalization or the treatment as set out in this instrument my condition will quickly deteriorate such that I would soon meet the standard for involuntary hospitalization.

\_\_\_\_\_ Other: *(Describe)* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The above options require a second physician’s opinion.

Yes \_\_\_\_\_ No \_\_\_\_\_

I waive the 2<sup>nd</sup> opinion requirement if another physician is not available.

Yes \_\_\_\_\_ No \_\_\_\_\_

*(If I require a second opinion and do not waive the requirement should no second physician be available, I understand that my advance directive may not become effective.)*

(7) NOMINATION OF GUARDIAN *(OPTIONAL)*: If a guardian of my person is to be appointed by a court, I nominate the following individual to be appointed as my guardian.

\_\_\_\_\_  
(Name of Individual) (Home Phone) (Work Phone)

\_\_\_\_\_  
(Address) (City) (State) (Zip)



**Q: When would power of attorney for health care take effect?**

A: It takes effect whenever you say that it should take effect, or when a doctor determines that you lack capacity.

**Q: Are there any steps that I need to take for the power of attorney for health care to take effect?**

A: You and two witnesses need to sign your power of attorney for health care in order for it to have legal effect. Anyone can serve as a witness. Once you and the two witnesses have signed, the document is legally effective, you do not need to do anything else.

**Q: Can I revoke my advance directive?**

A: Yes. You can revoke your advance directive at any time as long as you are considered to have capacity, except for the section giving your agent power of attorney.

**Q: How can I take back my agent's authority?**

A: There are two ways: First, you can sign a document saying that you are taking back the authority. Or, by personally telling your "supervising healthcare provider" as the law says you must.

**Q: What does my "supervising healthcare provider" mean?**

A: The doctor responsible for your care. If there is no doctor present, then the supervising healthcare provider is any medical professional responsible for your care at that time.

**Q: Why would I take back my agent's authority over my health care?**

A: As long as you have capacity, you can revoke your agent's authority for any reason. Some common examples include divorce from the agent, you or the agent moving to a different area, or feeling that you no longer need a power of attorney for health care.

**Q: If I give a person power of attorney for health care, can they make all of my health care decisions for me?**

A: That is up to you. You decide how much power your agent has. You can lay out exactly what types of health care decisions that your agent can make in your advance directive. The more directions you put in your advance directive, the more control you have over your agent.

**Q: What happens if my agent makes a decision that I do not like?**

A: Agents are expected to follow the directions in your advance directive. As long as the agent does not ignore your directions, the agent's decision will be final. If you do not have capacity, you cannot say no to a decision at the time the agent makes it, even if you disagree at that moment. This may be another reason to say clearly what decisions you want your agent to make and how you want him and her to decide in your advance directive. This could also be a reason not to make an advance directive.



**Q: What happens if the agent needs to make a decision that is not mentioned in my advance directive?**

A: The agent must make the decision according to your best interests.

**Q: How does the agent figure out my best interests?**

A: Your agent bases that decision on your personal values. There are a few ways for an agent to figure out what your personal values are. Some examples include your religious beliefs, the effect the treatment decision will have on your life expectancy, whether the treatment would cause you humiliation, or the amount of pain the treatment could cause you. The best way to help your agent figure out your personal values is to tell him or her and provide as many details as possible in your advance directive.

**Q: How should I decide when my advance directive takes effect?**

A: That is up to you. Most people choose to have the advance directive to take effect when a physician has determined that they lack capacity.

**Q: What is a “guardian”?**

A: A guardian is someone chosen by the court to make decisions for you when you are found to lack capacity. The difference between a guardian and an agent is that guardians require a court proceeding and the judge decides who the guardian will be. Also, guardians may have power over more than just your health care. They may have power to make your financial or legal decisions for you as well. If guardianship is mentioned, you should call Disability Rights Maine right away. DRM may be able to help you avoid this restrictive option.

**Q: What if I have an advance directive and a guardian?**

A: The guardian must follow your advance directive, unless they get a court order that says they do not.



**PART III: INSTRUCTIONS FOR HEALTH CARE**

*(Optional if you have appointed an agent. If giving instructions, you can choose those specific areas you wish to address and can add additional areas.)*

I request that I be provided the following treatment:

I. Alternatives to Hospitalization

In the event my condition becomes serious enough that I am found to need 24 hour care, I prefer to avoid hospitalization, and request that the following services be explored first.

\_\_\_\_\_Crisis Respite Services. I prefer to receive the services at the following agencies:

\_\_\_\_\_  
(Names of Agencies if You Have Preferences)

\_\_\_\_\_In-Home Services. I prefer to receive the following services:\_\_\_\_\_

\_\_\_\_\_  
(Names of Agencies if You Have Preferences & Description of Services)

\_\_\_\_\_Other Services: *(Describe)* \_\_\_\_\_

My reasons for wanting these services as alternatives to hospitalization are as follows:

*(Optional, but recommended)* \_\_\_\_\_

**Q: What if my agent disagrees with the instructions in my advance directive and gives my health care provider different directions?**

A: Your agent is required to follow your instructions. This means that you should be as clear and detailed as possible in the advance directive. If you have a detailed advanced directive, it is easier for your agents and doctors to **treat you the way you want.**



**Q: Do I need to list my reasons for wanting certain services?**

A: No. But, giving your reasons for wanting services can help your agent make other decisions. Remember, there may be times when your agent must make decisions that you did not predict in your advance directive. The agent must make those decisions according to your best interests and personal values. Listing your reasons for your decisions could help your agent figure out what those values are.

**II. Psychiatric Hospitalization**

In the event that psychiatric hospitalization is deemed the only suitable alternative, I direct that it be sought at the following hospitals in the following order of priority:

\_\_\_\_\_  
Name of Hospital

\_\_\_\_\_  
Name of Hospital

\_\_\_\_\_  
Name of Hospital

\_\_\_\_\_  
Name of Hospital

This directive may operate as my informed consent to admission as a voluntary patient to the above listed hospitals.

This consent shall operate even if I pose any verbal objections at the time.

Yes \_\_\_\_\_ No \_\_\_\_\_

If none of the above hospitals have available beds, this directive may operate as my informed consent to admission to any other hospital as follows: (*Select One*)

\_\_\_\_\_ To any other hospital, provided I do not object at the time.

\_\_\_\_\_ To any other hospital, even if I am objecting at the time, *except for the following listed hospitals:*

\_\_\_\_\_  
Name of Hospital to Which My Consent is *Not* Given

\_\_\_\_\_  
Name of Hospital to Which My Consent is *Not* Given

\_\_\_\_\_  
Name of Hospital to Which My Consent is *Not* Given



My reasons for wanting these psychiatric hospitalization options are as follows:

*(Optional, but recommended)* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If I am to be transported to a psychiatric hospital as an involuntary patient, I request that I be transported by the following means:

\_\_\_\_\_ Ambulance  
\_\_\_\_\_ Sheriff or police vehicle. (I understand that by requesting this service I am waiving any claims or rights I may have under law to be transported in a medically equipped vehicle in the company of emergency medical technicians or other medically trained personnel.)

Other notes regarding transportation and my reasons for requesting transportation by this means are as follows: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Q: What is “informed consent”?**

A: Informed consent means knowing and agreeing to the information about your treatment and understanding whether there are other treatment options available. For informed consent, there should be a conversation between you and your doctor. The doctor will share important information with you about a treatment or procedure. This information can include details about the procedure, recovery time, risks and benefits of the treatment or procedure, or risks and benefits of choosing a different treatment or procedure. You can ask questions of your doctor about any of his or her opinions or recommendations.

**Q: Can I have informed consent if I do not have capacity?**

A: No. If you lack capacity it means that you cannot legally make informed decisions about your health care. You can use your advance directive as informed consent to certain treatment options in the future. To do this, you should have conversations with your doctor about treatments that you are willing to accept, treatments that the doctor recommends, and treatments that have worked or not worked for you in the past. Once you figure out a treatment plan that works for you, your advance directive can show that



you have informed consent to a future treatment. If you choose not to use the advance directive as informed consent, your agent may end up making a decision for you that you would not have made yourself.

**Q: What happens if I do not pick a transportation option?**

A: This option is there as a way for you to give your preferred transportation method if you are deemed to be in psychiatric crisis. Keep in mind that choosing ambulance, for example, does not guarantee an ambulance will be available to take you to the hospital during a crisis.

III. Medications

\_\_\_\_\_ I consent and my agent, if appointed, is authorized to consent to the administration of medications as follows:

Medication	Dosage Limits, If Any	Only Orally (If Checked)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

\_\_\_\_\_ All medications as prescribed by my primary physician, except as may be limited below.

\_\_\_\_\_ All medications as authorized by my agent, if appointed, except as may be limited below.

\_\_\_\_\_ I do not authorize and my agent, if appointed, may not consent to the following medications:

Medications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

My reasons for not consenting to the above medications are as follows:

*(Optional, but recommended)* \_\_\_\_\_



\_\_\_\_\_ If any action can be taken to eliminate my above stated concerns regarding the excluded medications, my agent, if appointed, is authorized to consent to their administration provided such additional action is taken to accommodate my stated concerns.

\_\_\_\_\_ Other instructions with regard to medications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Q: What if my doctor wants to give me a different medication from the ones that I list?**

A: The doctor needs informed consent to give you medication, unless there is a medical emergency. If the doctor wants to give you a new medication that you never learned about and you lack capacity, the doctor needs your agent's informed consent.

**Q: Can my doctor refuse to use a medication or treatment that I list in my advance directive?**

A: Yes. There are three reasons that a doctor can refuse to follow your treatment instructions:

- 1) there is a medical emergency (including psychiatric emergencies) that requires different treatment;
- 2) providing the medications or treatments you chose goes against the doctor's conscience; or
- 3) the doctor believes that the medication or treatment you chose would not actually help you get better.

**Q: What happens if the doctor will not follow the instructions in my advance directive?**

A: The doctor is supposed to tell you and/or your agent that he or she is not going to follow your instructions. This is not guaranteed. Then, the doctor will arrange to have you transferred to someone who will follow your instructions. The doctor must continue to treat you until you are transferred to a new doctor.

**Q: What if the doctor tells my agent that one of the medications that I do not want is necessary and the agent gives the doctor consent?**

A: Unless there is an emergency, they must follow your advance directive. If the doctor refuses, he or she must transfer you to someone who will follow it. If you say in your advance directive that you do not want a specific medication, the agent cannot later give the doctor permission to use it.

**Q: So, a doctor can give me a medication without my consent or the consent of my agent?**

A: Yes. If you are deemed to be in a psychiatric crisis, a doctor may treat you in whatever way the doctor believes is best.



**Q: Do I need to list my reasons for not consenting to certain medications?**

A: No. You can refuse any medication for any reason and you do not need to explain why. But, giving your reasons for refusing a medication can help your agent and doctor decide the next best treatment for you. Any time you provide examples of your personal values, it will help your agent make decisions that you did not mention in your advance directive. Putting as much information as possible in the advance directive can help your doctor see what has worked for you in the past and why you want certain treatments over others. For example, a certain medication may cause you to have a terrible reaction. You would want to state that and describe the reaction in your advance directive.

**Q: What does “any action...to eliminate my above stated concerns regarding the excluded medications” mean?**

A: It means that the doctor may know a way to avoid the issues that you have with the medication. For example, maybe you do not want a specific medication because of its side effects. If the doctor knows a way to minimize those side effects, and the medication is the best form of treatment, you can choose this option.

**IV. Emergency Interventions While in a Hospital**

I understand that while I am in a psychiatric facility certain interventions may be authorized in an emergency should I be deemed to be imminently dangerous to myself or others.

I believe such an emergency can be avoided if I am treated in the following way: \_\_\_\_\_

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If an emergency nevertheless arises, I prefer emergency interventions be implemented as follows: *(State preferences with regard to the use of seclusion, restraint, offer of oral medications, medications by injection, etc.):*

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**V. Other Treatment While in a Hospital**

I have responded favorably to the following treatment in a hospital setting, and request that these treatment options be offered.



Describe treatment options (family therapy, for example) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## VI. Treatments to Avoid While in a Hospital

I have responded unfavorably to the following treatment in a hospital setting, and request that these treatment options be avoided.

Describe treatment options (electroconvulsive therapy, for example) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### **Q: Can I deny consent for certain emergency treatment options?**

A: No. A psychiatric emergency means that your doctor can ignore your advance directive. But, you can ask for a treatment in your advance directive that has helped you avoid emergencies in the past. It can be helpful to mention any treatment or medication that has worked or not worked for you in the past. This will make it more likely that you are treated the way you want, even in an emergency. However, in an emergency situation, the doctor can act according to his or her best judgment. Sometimes, that means ignoring your advance directive. This rule lasts only during the emergency.

### **Q: Who decides whether there is an emergency?**

A: It is up to the person who is treating you to decide whether there is an emergency. He or she makes that decision based on their medical judgment as to whether you are dangerous to yourself or others.

### **Q: Does a doctor have to listen to my wishes during an emergency?**

A: No. Describing your preferences in your advance directive may be helpful. But if there is an emergency the doctor or nurse is not required to follow those directions.



**Q: Can my agent make treatment decisions in an emergency?**

A: No. Just like with your advance directive, your agent can suggest treatment options but doctors are free to make their own decisions until they decide the emergency ends.

**VII. Electroconvulsive Therapy (ECT)**

\_\_\_\_\_ I do not consent and my agent is not authorized to consent to the administration of ECT.

\_\_\_\_\_ I consent to the administration of ECT as prescribed by my primary physician, except as may be limited below.

\_\_\_\_\_ I consent to the administration of ECT as authorized by my agent, except as may be limited below.

\_\_\_\_\_ Limitations upon consent to the administration of ECT:

\_\_\_\_\_ My consent is limited to \_\_\_\_\_ number of treatments.

\_\_\_\_\_ Consent may not be sought from my agent, if one is appointed, until he/she/they has/have had \_\_\_\_\_ days to consider the risks and benefits of the treatment.

\_\_\_\_\_ My consent is otherwise limited as follows: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

My reasons for consenting or refusing ECT as set out above, are as follows:

*(Optional, but recommended)* \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ I direct that Disability Rights Maine (Phone: 800.452.1948 or Fax: 207.621.1419) be informed of any ECT treatment that I am to receive before I am to receive it and with enough advance notice so that DRM may contact me prior to the administration of any ECT treatment.

**Q: What is electroconvulsive therapy?**

A: It is short electric shocks to your brain while you are unconscious. It is prescribed by some doctors for certain mental health conditions.



**Q: Why is ECT specifically listed here?**

A: ECT has a long and controversial history. It is important that you know it could be considered by your doctor so you should address it in your advance directive. If your doctor suggests ECT may be necessary, **you are encouraged to contact Disability Rights Maine at 800.452.1948.**

**Q: Can I control whether I receive ECT?**

A: You can refuse ECT, but there are several ways for your doctor to still use it without your consent. Because of ECT’s controversial history, physicians need informed consent in writing before they can use it, even if the doctor claims there is a psychiatric emergency. If a doctor finds that you lack capacity, he or she can use ECT if a court orders the use of ECT, or your guardian, other, legal decision maker or agent gives written informed consent. If the facility or out-patient treatment center says that any of the above rules regarding ECT do not apply, **you are encouraged to contact Disability Rights Maine at 800.452.1948.**

VIII. Notices

If I am admitted to a facility, I request that the following individuals be notified immediately:

\_\_\_\_\_  
(Name of Individual) (Home Phone) (Work Phone)

\_\_\_\_\_  
(Address) (City) (State) (Zip)

\_\_\_\_\_  
(Name of Individual) (Home Phone) (Work Phone)

\_\_\_\_\_  
(Address) (City) (State) (Zip)

IX. Child Care Arrangements

If I am to be admitted to residential care or to a hospital, or I am otherwise unable to care for my children, and I have not made prior child care arrangements, I authorize my agent to make those arrangements. If my agent or alternative is not available, I request that the following individual be contacted to care for my children temporarily:



(Name of Individual)	(Home Phone)	(Work Phone)
(Address)	(City)	(State) (Zip)
X. Other Instructions		

**Q: Do I need to list my agent in this section?**

A: No. You do not need to list your agent as one of the people who are notified if you are brought to a psychiatric hospital. However, you should make sure that your agent is told if that happens. One way to do that is by listing his or her information here. That way, your agent will be able to make informed decisions for you as soon as possible.

**Q: What if none of the people I have chosen are available to care for my children?**

A: Just like with your health care, your agent should make decisions in line with your personal values. That means that the agent should look at the people you have listed and try to find the person that closely matches that description. For example, if you only listed your siblings but none are available, your agent could assume you want family taking care of your children and reach out to your cousins.



**PART IV: PRIMARY PHYSICIAN**

I designate the following as my primary physician, for the purposes of this directive:

\_\_\_\_\_  
(Name of Physician) (Phone Number)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(City) (State) (Zip Code)

**A COPY OF THIS FORM HAS THE SAME EFFECT AS THE ORIGINAL**

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Witness Name Witness Name

\_\_\_\_\_  
Witness Signature Witness Signature

\_\_\_\_\_  
Witness Address Witness Address

\_\_\_\_\_  
City State Zip Code City State Zip Code

Dated: \_\_\_\_\_ Dated: \_\_\_\_\_

**Q: Why is it important to have a primary physician?**

A: Your primary physician is the doctor that you will go to for treatment, as long as he or she is available. Hopefully, this is someone you already have a relationship with and that you trust. They can be the one that you designate to decide whether you have capacity. If they know you better, they may have a better idea as to whether you have capacity.

**Q: Do I need to appoint a primary physician?**

A: No. You do not need to choose a primary physician.



**Q: What happens if my primary physician is not available or I do not choose one in advance?**

A: If your primary physician is unavailable or you do not have a designated primary physician, the doctor who treats you will be considered your primary physician.

**CERTIFICATE OF CAPACITY**

I, \_\_\_\_\_, being a licensed \_\_\_\_\_  
Name Physician or Psychologist

state that I know \_\_\_\_\_, and, as of the date of this statement, believe him/her/they to have capacity to execute a health care advance directive in that s/he understands the following:

His/her/their diagnosis;

Significant benefits, risks and alternatives to various treatment options; and

The consequences of not accepting recommended treatment.

I further believe that \_\_\_\_\_ can make and communicate a health care decision and he/she/they understands the consequences of naming someone else to make health care decisions under a power of attorney.

\_\_\_\_\_  
Signature Dated: \_\_\_\_\_

**Q: When would I use this form?**

A: This form is signed by your primary physician. It allows him or her to say in writing that you are capable of making an advance directive. The doctor will sign this if they know that you know the pros and cons of an advance directive.



**SECTION III: THE UNIFORM HEALTH  
CARE DECISIONS ACT**

**SECTION 803: ADVANCE HEALTH CARE DIRECTIVES**



C10120

**§5-803. Advance health care directives**

**1. Individual instruction.** An adult or emancipated minor with capacity may give an individual instruction. The instruction may be oral or written. The instruction may be limited to take effect only if a specified condition arises. An oral instruction is valid only if made to a health care provider or to an individual who may serve as a surrogate under section 5-806, subsection 2.

[PL 2017, c. 402, Pt. A, §2 (NEW); PL 2019, c. 417, Pt. B, §14 (AFF).]

**2. Power of attorney for health care.** An adult or emancipated minor with capacity may execute a power of attorney for health care, which may authorize the agent to make any health care decision the principal could have made while having capacity. The power must be in writing and signed by the principal and 2 witnesses. Notwithstanding any law validating electronic or digital signatures, signatures of the principal and witnesses must be made in person and not by electronic means. The power remains in effect notwithstanding the principal's later incapacity and may include individual instructions. Unless related to the principal by blood, marriage or adoption, an agent may not be an owner, operator or employee of a residential long-term health care institution at which the principal is receiving care.

[PL 2017, c. 402, Pt. A, §2 (NEW); PL 2019, c. 417, Pt. B, §14 (AFF).]

**3. Effective upon determination that principal lacks capacity.** Unless otherwise specified in a power of attorney for health care, the authority of an agent becomes effective only upon a determination that the principal lacks capacity and ceases to be effective upon a determination that the principal has recovered capacity.

[PL 2017, c. 402, Pt. A, §2 (NEW); PL 2019, c. 417, Pt. B, §14 (AFF).]

**4. Determination.** Unless otherwise specified in a written advance health care directive, a determination that an individual lacks or has recovered capacity or that another condition exists that affects an individual instruction, the authority of an agent or the validity of an advance health care directive must be made by the primary physician, by a court of competent jurisdiction or, for an individual who has included a directive authorizing mental health treatment in an advance health care directive, by a person qualified to conduct an examination pursuant to Title 34-B, section 3863.

[PL 2017, c. 402, Pt. A, §2 (NEW); PL 2019, c. 417, Pt. B, §14 (AFF).]

**5. Decision in accordance with instructions, wishes, best interest.** An agent shall make a health care decision in accordance with the principal's individual instructions, if any, and other wishes to the extent known to the agent. Otherwise, the agent shall make the decision in accordance with the agent's determination of the principal's best interest. In



determining the principal's best interest, the agent shall consider the principal's personal values to the extent known to the agent.

[PL 2017, c. 402, Pt. A, §2 (NEW); PL 2019, c. 417, Pt. B, §14 (AFF).]

**6. Effective without judicial approval.** A health care decision made by an agent for a principal is effective without judicial approval.

[PL 2017, c. 402, Pt. A, §2 (NEW); PL 2019, c. 417, Pt. B, §14 (AFF).]

**7. Nomination of guardian.** A written advance health care directive may include the individual's nomination of a guardian of the person.

[PL 2017, c. 402, Pt. A, §2 (NEW); PL 2019, c. 417, Pt. B, §14 (AFF).]

**8. Validity of advance health care directive.** An advance health care directive is valid for purposes of this Part if it complies with this Part, regardless of when or where executed or communicated, or if it is valid under the laws of the state in which it was executed. An advance health care directive that is valid where executed or communicated is valid for the purposes of this Part.

[PL 2017, c. 402, Pt. A, §2 (NEW); PL 2019, c. 417, Pt. B, §14 (AFF).]

**9. Directing mental health treatment.** An advance health care directive is valid for purposes of directing mental health treatment. The terms of the directive must be construed in accordance with this Part and Title 34-B, sections 3831 and 3862.

[PL 2017, c. 402, Pt. A, §2 (NEW); PL 2019, c. 417, Pt. B, §14 (AFF).]

**10. Personal representative for purposes of federal law.** A surrogate or an agent named in an advance health care directive has the power and authority to serve as the personal representative of the patient who executed the health care directive for all purposes of the federal Health Insurance Portability and Accountability Act of 1996, 42 United States Code, Section 1320d et seq. and its regulations, 45 Code of Federal Regulations, Parts 160-164. The surrogate or agent has all the rights of the patient with respect to the use and disclosure of the individually identifiable health information and other medical records of the patient.

[PL 2017, c. 402, Pt. A, §2 (NEW); PL 2019, c. 417, Pt. B, §14 (AFF).]

#### SECTION HISTORY

PL 2017, c. 402, Pt. A, §2 (NEW). PL 2017, c. 402, Pt. F, §1 (AFF). PL 2019, c. 417, Pt. B, §14 (AFF).

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