

NOTICE TO PERSON MAKING AN ADVANCE DIRECTIVE FOR PSYCHIATRIC CARE

THIS IS AN IMPORTANT LEGAL DOCUMENT. IT CREATES AN ADVANCE DIRECTIVE FOR PSYCHIATRIC CARE. BEFORE SIGNING THIS DOCUMENT YOU SHOULD KNOW THESE IMPORTANT FACTS:

THIS DOCUMENT ALLOWS YOU TO MAKE DECISIONS IN ADVANCE ABOUT CERTAIN TYPES OF PSYCHIATRIC CARE. THE INSTRUCTIONS YOU INCLUDE IN THIS ADVANCE DIRECTIVE WILL BE FOLLOWED IF TWO PROVIDERS OF HEALTH CARE, ONE OF WHOM MUST BE A PHYSICIAN OR LICENSED PSYCHOLOGIST AND THE OTHER OF WHOM MUST BE A PHYSICIAN, A PHYSICIAN ASSISTANT, A LICENSED PSYCHOLOGIST, A PSYCHIATRIST OR AN ADVANCED PRACTICE REGISTERED NURSE WHO HAS THE PSYCHIATRIC TRAINING AND EXPERIENCE PRESCRIBED BY THE STATE BOARD OF NURSING PURSUANT TO NRS 632.120, DETERMINES THAT YOU ARE INCAPABLE OF MAKING OR COMMUNICATING TREATMENT DECISIONS. OTHERWISE YOU WILL BE CONSIDERED CAPABLE TO GIVE OR WITHHOLD CONSENT FOR THE TREATMENTS. YOUR INSTRUCTIONS MAY BE OVERRIDDEN IF YOU ARE BEING HELD IN ACCORDANCE WITH CIVIL COMMITMENT LAW. BY EXECUTING A DURABLE POWER OF ATTORNEY FOR HEALTH CARE AS SET FORTH IN NRS 162A.700 TO 162A.870, INCLUSIVE, AND SECTIONS 3 TO 56, INCLUSIVE, OF THIS ACT, YOU MAY ALSO APPOINT A PERSON AS YOUR AGENT TO MAKE TREATMENT DECISIONS FOR YOU IF YOU BECOME INCAPABLE. THIS DOCUMENT IS VALID FOR TWO YEARS FROM THE DATE YOU EXECUTE IT UNLESS YOU REVOKE IT. YOU HAVE THE RIGHT TO REVOKE THIS DOCUMENT AT ANY TIME YOU HAVE NOT BEEN DETERMINED TO BE INCAPABLE. YOU MAY NOT REVOKE THIS ADVANCE DIRECTIVE WHEN YOU ARE FOUND INCAPABLE BY TWO PROVIDERS OF HEALTH CARE, ONE OF WHOM MUST BE A PHYSICIAN OR LICENSED PSYCHOLOGIST AND THE OTHER OF WHOM MUST BE A PHYSICIAN, A PHYSICIAN ASSISTANT, A LICENSED PSYCHOLOGIST, A PSYCHIATRIST OR AN ADVANCED PRACTICE REGISTERED NURSE WHO HAS THE PSYCHIATRIC TRAINING AND EXPERIENCE PRESCRIBED BY THE STATE BOARD OF NURSING PURSUANT TO NRS 632.120. A REVOCATION IS EFFECTIVE WHEN IT IS COMMUNICATED TO YOUR ATTENDING PHYSICIAN OR OTHER HEALTH CARE PROVIDER. THE PHYSICIAN OR OTHER PROVIDER SHALL NOTE THE REVOCATION IN YOUR MEDICAL RECORD. TO BE VALID, THIS ADVANCE DIRECTIVE MUST BE SIGNED BY TWO QUALIFIED WITNESSES, PERSONALLY KNOWN TO YOU, WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE. IT MUST ALSO BE ACKNOWLEDGED BEFORE A NOTARY PUBLIC.

NOTICE TO PHYSICIAN OR OTHER PROVIDER OF HEALTH CARE

Under Nevada law, a person may use this advance directive to provide consent or refuse to consent to future psychiatric care if the person later becomes incapable of making or communicating those decisions. By executing a durable power of attorney for health care as set

forth in NRS 162A.700 to 162A.870, inclusive, and sections 3 to 56, inclusive, of this act, the person may also appoint an agent to make decisions regarding psychiatric care for the person when incapable. A person is “incapable” for the purposes of this advance directive when in the opinion of two providers of health care, one of whom must be a physician or licensed psychologist and the other of whom must be a physician, a physician assistant, a licensed psychologist, a psychiatrist or an advanced practice registered nurse who has the psychiatric training and experience prescribed by the State Board of Nursing pursuant to NRS 632.120, the person currently lacks sufficient understanding or capacity to make or communicate decisions regarding psychiatric care. If a person is determined to be incapable, the person may be found capable when, in the opinion of the person’s attending physician or an advanced practice registered nurse who has the psychiatric training and experience prescribed by the State Board of Nursing pursuant to NRS 632.120 and has an established relationship with the person, the person has regained sufficient understanding or capacity to make or communicate decisions regarding psychiatric care. This document becomes effective upon its proper execution and remains valid for a period of 2 years after the date of its execution unless revoked. Upon being presented with this advance directive, the physician or other provider of health care must make it a part of the person’s medical record. The physician or other provider must act in accordance with the statements expressed in the advance directive when the person is determined to be incapable, except as otherwise provided in NRS 449A.636. The physician or other provider shall promptly notify the principal and, if applicable, the agent of the principal, and document in the principal’s medical record any act or omission that is not in compliance with any part of an advance directive. A physician or other provider may rely upon the authority of a signed, dated, and witnessed or notarized advance directive.

ADVANCE DIRECTIVE FOR PSYCHIATRIC CARE

I, _____, being an adult of sound mind or an emancipated minor, willfully and voluntarily make this advance directive for psychiatric care to be followed if it is determined by two providers of health care, one of whom must be my attending physician or a licensed psychologist and the other of whom must be a physician, a physician assistant, a licensed psychologist, a psychiatrist or an advanced practice registered nurse who has the psychiatric training and experience prescribed by the State Board of Nursing pursuant to NRS 632.120, that my ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that I lack the capacity to refuse or consent to psychiatric care. I understand that psychiatric care may not be administered without my express and informed consent or, if I am incapable of giving my informed consent, the express and informed consent of my legally responsible person, my agent named pursuant to a valid durable power of attorney for health care or my consent expressed in this advance directive for psychiatric care. I understand that I may become incapable of giving or withholding informed consent or refusal for psychiatric care due to the symptoms of a diagnosed mental disorder. These symptoms may include:

PSYCHOACTIVE MEDICATIONS

If I become incapable of giving or withholding informed consent for psychiatric care, my instructions regarding psychoactive medications are as follows: *(Place initials beside choice.)*

I consent to the administration of the following medications:

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

Conditions or limitations: _____

ADMISSION TO AND RETENTION IN FACILITY

If I become incapable of giving or withholding informed consent for psychiatric care, my instructions regarding admission to and retention in a medical facility for psychiatric care are as follows: *(Place initials beside choice.)*

I consent to being admitted to a medical facility for psychiatric care.

My facility preference is: _____

I do not consent to being admitted to a medical facility for psychiatric care.

This advance directive cannot, by law, provide consent to retain me in a facility beyond the specific number of days, if any, provided in this advance directive. Conditions or limitations:

ADDITIONAL INSTRUCTIONS

These instructions shall apply during the entire length of my incapacity. In case of a mental health crisis, please contact:

1. Name: _____

Address: _____

Home Telephone Number: _____

Work Telephone Number: _____

Relationship to Me: _____

2. Name: _____

Address: _____

Home Telephone Number: _____

Work Telephone Number: _____

Relationship to Me: _____

3. My physician:

Name: _____

Work Telephone Number: _____

4. My therapist or counselor:

Name: _____

Work Telephone Number: _____

The following may cause me to experience a mental health crisis: _____

The following may help me avoid a hospitalization: _____

I generally react to being hospitalized as follows: _____

Staff of the hospital or crisis unit can help me by doing the following: _____

I give permission for the following person or people to visit me: _____

2. The principal's attending physician or provider of health care or an employee of the physician or provider; or
3. The owner or operator, or employee of the owner or operator, of a medical facility in which the principal is a patient or resident.

Witnessed by:

Witness: _____
Signature Date

Witness: _____
Signature Date

CERTIFICATION OF NOTARY PUBLIC

STATE OF NEVADA
COUNTY OF _____

This instrument was acknowledged before me on the ____ day of _____,
_____ by _____.

Notary Public