Psychiatric Advance Directive (PAD)/Crisis Plan*
New Jersey Advance Directives for Mental Health Care Act
NJSA 26:2H-108 et seq.

Name: D.O.B.: Phone:

Address:

I,_____, being a legal adult of sound mind, voluntarily make this declaration for mental health treatment.

I. Activation of Psychiatric Advance Directive (PAD)

Please select and initial one of the following statements:

_____ I want this declaration to be followed if I am incapable of making a decision or decisions about my care, as defined in New Jersey Statutes Annotated 26:2H-109.

_____ In the absence of a declaration of incapacity, I want this declaration to be followed as if I am incapable of making a decision or decisions about my care, as defined in New Jersey Statutes Annotated 26:2H-109, when signs and symptoms listed in PART 2 are evident.

II. Modifying, suspending or revoking PAD plan

Please select and initial one of the following statements:

_____ I can modify, suspend or revoke my PAD at any time as permitted by law.

OR

_____ I do not wish to modify, suspend or revoke my PAD while it is invoked.

III. Option to appoint Mental Health Care Representative

_____ I do not wish to appoint a mental health care representative.

OR

_____ I wish to appoint a mental health care representative.

If it is determined that I am unable to make informed health care decisions for myself, I want the following person to act as my primary mental health care representative:

Name	Relationship to self	Phone 1
		Phone 2
Address		Email

I would like the following person to be my alternate mental health care representative:

Name	Relationship to self	Phone 1
		Phone 2
Address		Email

*Adapted from the Wellness and Recovery Action Plan (WRAP®) Crisis Plan. Copyright by Mary Ellen Copeland PO Box 301, W. Dummerston, VT 05357 Phone: (802) 254-2092 www.mentalhealthrecovery.com

If you have designated someone as your mental health care representative, please answer sections A and B by initialing one of the statements. If you do not wish to appoint someone as your representative, do not complete this page.

A) **Authority and Limitation of Authority of Mental Health Care Representative**

I want my representative to make decisions about my treatment in the following way: **(Please select and initial one of the following statements.)**

_____ Make decisions about my care based on what is in this document or, if not specifically expressed, as are otherwise known to my representative. If my wishes are unknown or are not specifically addressed in this document, make decisions based on what he/she believes would be the decision I would make.

_____ Make decisions about my care based on what is in this document or, if not specifically expressed, as are otherwise known to my representative. If my wishes are unknown or are not specifically addressed in this document, make decisions about my care that he/she thinks would be in my best interest, taking into consideration my preferences and consultation with providers and supporters as indicated in this document.

B) **Please select and initial one of the following statements:**

_____ I consent to giving my representative the authority to admit me to an inpatient or partial psychiatric hospitalization program for up to_____days.

Optional: Describe the conditions under which you would agree to be hospitalized:

_____

_____

_____

_____ I do not consent to give my representative the authority to admit me to an inpatient or partial psychiatric hospitalization program.

Name (Print):

The following are my wishes regarding my mental health care treatment in the event of a mental health crisis, including hospitalization:

Part 1. The following words describe me when I am feeling well:

Part 2. Symptoms

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

Substance Use (Street Drugs/Alcohol/Prescription Medications)

Without admitting to current use of substances, I offer the following information: This is the

substance(s) that I am or was most likely to use:

I feel and behave this way after taking this drug(s):

Part 3. Supporters

In the event that I am in a mental health crisis please contact the following person(s) in addition to any representatives named:

Name	Relationship to self	Phone 1 Phone 2
Name	Relationship to self	Phone 1 Phone 2
Name	Relationship to self	Phone 1 Phone 2

I do not want the following people notified or involved in my care or treatment in any way: Name I do not want them involved because: (Optional)

Name	I do not want them involved because: (Optional)

If I am admitted to a hospital, I will need assistance with the following tasks:

I need (Name)_____ To (tasks) _____

I need (Name)_____ To (tasks) _____

I need (Name)_____ To (tasks) _____

I need (Name)_____ To (tasks) _____

I need (Name)_____ To (tasks) _____

I am a caretaker of the following person(s) at home:

The following person should be contacted to arrange substitute care:

Name	Phone 1 Phone 2

Part 4. Medical Information

Primary Care Physician		Phone
Psychiatrist		Phone
Therapist		Phone
Case Manager		Phone
Pharmacy		Phone
Insurance Carrier	ID #	Phone

I would like the following health care providers to be notified and consulted about my care:

I have the following medical conditions:

Medications/Supplements/OTC (Over the Counter) preparations I am currently using:

Name	Dosage	Purpose
Name	Dosage	Purpose
Name	Dosage	Purpose
Name	Dosage	Purpose
Name	Dosage	Purpose
Name	Dosage	Purpose

Medications that have helped me in the past and that I consent to:

Name	Dosage	Purpose
Name	Dosage	Purpose
Name	Dosage	Purpose
Name	Dosage	Purpose

Medications that I do not consent to or wish to avoid:

Name or type of medication	Reason Why
Name or type of medication	Reason Why
Name or type of medication	Reason Why
Name or type of medication	Reason Why

Medications that I am allergic to:

Name	Reaction
Name	Reaction

Part 5: Help from my supporters and hospital staff

Please do the following things that would help reduce my symptoms, make me more comfortable, and keep me safe:

Please AVOID doing the following things while I am in a crisis, as they may make me feel worse:

Part 6. Home care/Community care/Respite center
If possible, follow this care plan instead of hospitalization:

Part 7. Hospital or other Treatment Facilities
If I am being admitted to a hospital or treatment facility, I prefer the following facilities in order of preference:

1.	Name	Reason I prefer it
2.	Name	Reason I prefer it

AVOID using the following hospital or treatment facilities:

1.	Name	Reason to avoid it
2.	Name	Reason to avoid it

Part 8: Treatments and Therapies

The following treatments and therapies help me when I am in crisis:

Name	When to use this therapy
Name	When to use this therapy

Treatments and Interventions that I do not consent to:

Name	Reason why
Name	Reason why

I would like to be permitted to use the following wellness techniques to help me in my recovery:

Part 9: Inactivating the Plan

The following signs, lack of symptoms or actions indicate that my supporters no longer need to use this plan and I am able to make decisions on my own behalf:

Signature of Declarant:

I,_____, being a legal adult of sound mind, voluntarily make this declaration for mental health treatment.

Signature_____ Date _____

Print Name _____

Any Mental Health Care Advance Directive plan signed with a more recent date takes precedence over this one.

Witness:

I attest that the declarant signed this document (or asked another to sign this document on his or her behalf) in my presence, and that the declarant appears to be of sound mind and free of duress and undue influence. I am 18 years of age or older. I am not designated by this or any other document as the person's mental health care representative, nor as an alternate mental health care representative. At the time this document is being executed, I am not the responsible mental health care professional responsible, or directly involved with, the declarant's care.

Witnessed by_____ Date _____

Print Name _____

Second Witness:
(A second witness is required if the first witness is related to the declarant by blood, marriage or adoption, or is the declarant's domestic partner or otherwise shares the same home with the declarant; is entitled to any part of the declarant's estate by will or by operation of law at the time the advance directive is being executed; or is an operator, administrator, or employed of a rooming or boarding or residential health care facility in which the declarant resides.)

I attest that the declarant signed this document (or asked another to sign this document on his or her behalf) in my presence, and that the declarant appears to be of sound mind and free of duress and undue influence. I am 18 years of age or older. I am not designated by this or any other document as the person's mental health care representative, nor as an alternate mental health care representative. At the time this document is being executed, I am not the responsible mental health care professional responsible, or directly involved with, the declarant's care.

Witnessed by:_____ Date: _____

Print Name _____

_____This plan has been voluntarily registered with the State of New Jersey Division of Mental Health and Addiction Services Psychiatric Advance Directive Registry, operated and maintained by U.S. Living Will Registry.

If you have any additional instructions or notes, please include them here.