SEND DIRECTIVE WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

PSYCHIATRIC ADVANCE DIRECTIVE

- **THIS PSYCHIATRIC ADVANCE DIRECTIVE CANNOT BE USED TO REFUSE INVOLUNTARY EMERGENCY PROCEDURE OR COMMITMENT. ***
- **USE OF AN INVOLUNTARY EMERGENCY PROCEDURE DOES NOT INVALIDATE THIS FORM. ***
- A physician's signature is NOT required to make a Colorado PAD effective.
- A copy of this directive is as effective as the original.
- This form is intended for use in all situations. The form is effective and controlling once all pages are completed.

Legal Last Name			
Legal First Name / Middle Name			
Date of Birth		Gender	
Eye Color	Hair Color	Race	Ethnicity

This Form is Colorado's **PSYCHIATRIC ADVANCE DIRECTIVE (PAD).** The instructions **MUST BE COMPLIED WITH** unless substantial harm to the Person will result. It is also known as a Behavioral Health Orders for Scope of Treatment Directive. If substantial harm to the Person will result, the Person's Agent should be contacted for alternative treatment options.

ESSENTIAL INFORMATION & SUMMARY of IMPORTANT INSTRUCTIONS for TREATMENT:

_____
_____
_____

If known, my primary behavioral health diagnosis and date of diagnosis:

_____

I have been diagnosed with the following mental health and substance use condition(s) in addition to my primary diagnosis:_____
_____

I experience the following TYPES OF BELIEFS AND BEHAVIORS when my behavioral health condition(s) are not well managed: _____
_____
_____

Performing these ACTIONS will help me to feel SAFE and CALM:_____
_____
_____

Performing these ACTIONS will cause me to feel UNSAFE and DISTRESSED**:**_____
_____
_____

My Primary Agent _____ Phone_____
My Health Care Provider _____ Phone _____
Health Care Organization _____ Phone _____

***EMERGENCY AND INVOLUNTARY PROCEDURES:**

An Instruction exempting a Person from involuntary emergency procedure or commitment authorized pursuant to state law is void and should be disregarded, however, the remainder of the PAD remains valid and binding upon a physician or other provider. This completed PAD must be followed unless "substantial harm will result" to the Person. For example, an M-1 Hold and emergency medications may be initiated regardless of the Person's instructions, while administering non-emergency medications requires application of the Person's instructions unless substantial harm will result. If such harm would result, the physician or other provider must make a good faith effort to contact the Person's Agent for alternative instructions, as applicable, before administering alternative medications under normal operating procedures.

HIPAA AND C.R.S. 27-65-121 PERMIT DISCLOSURE OF THIS FORM BETWEEN HEALTHCARE PROFESSIONALS

 Date_____ Person's Initials_____ Witness Initials_____ Witness Initials_____

SECTION II. MEDICAL HISTORY

❑ **I do not wish to include my medical information.**

A. I have the following medical diagnoses (i.e. diabetes, asthma, etc.):

_____
_____
_____
_____

❑ I have attached additional pages to provide more information about my medical conditions.

B. I take the following medications for medical conditions:

Medication:_____Reason:_____
Medication:_____Reason:_____
Medication:_____Reason:_____
Medication:_____Reason:_____

❑ I do not take medications for my health maintenance
❑ I have attached additional pages as necessary

SECTION III. SECLUSION AND RESTRAINT

The following actions, therapies and/or treatments should be tried before using seclusion or restraints:

_____ Reason_____
_____Reason_____
_____Reason_____
_____ Reason_____

❑ **I prefer the use of seclusion only** ❑ **I prefer the use of seclusion and restraints**

SECTION IV. PSYCHIATRIC MEDICATIONS

A. The following medications are THE MOST EFFECTIVE for my behavioral health treatment:

Medication:_____Reason:_____
Medication:_____Reason:_____
Medication:_____Reason:_____
Medication:_____Reason:_____

❑ I have attached additional pages as necessary

B. I consent to take these medications, if prescribed:

Medication:_____Reason:_____
Medication:_____Reason:_____
Medication:_____Reason:_____
Medication:_____Reason:_____

❑ I have attached additional pages as necessary

C. I prefer to AVOID THESE SIDE EFFECTS from medications:

_____Reason_____
_____Reason_____
_____Reason_____
_____Reason_____

- ❑ I have attached additional pages as necessary
- ❑ I agree to maintenance medication adjustments when discussed with me by my healthcare provider(s)

D. I do NOT consent to taking the following medications :

Medication:_____Reason:_____
Medication:_____Reason:_____
Medication:_____Reason:_____
Medication:_____Reason:_____

- ❑ I have attached additional pages as necessary

SECTION V. EXAMINATIONS, PROCEDURES, THERAPIES & TREATMENTS

Examinations are performed to determine the cause of symptoms and to establish diagnoses. Procedures include therapy and other healthcare treatments intended to assist a person change their thinking, behavior, emotions, how a person perceives and understands situations or their physical condition.

Examples include but are not limited to group therapy, one-on-one therapy, blood draws, starting an IV, authority to administer by injection, laboratory tests, and electroconvulsive therapy. No instructions on this PAD will create an exemption from lawful emergency or involuntary procedure.

A. If recommended, I consent to the following examinations, procedures, therapies, and treatments:

_____Reason_____
_____Reason_____
_____Reason_____
_____Reason_____

- ❑ I have attached additional pages as necessary

B. ❑ I **do NOT** consent to alternative examinations, procedures, therapies and treatments recommended by my healthcare provider(s).

C. ❑ I **consent** to alternative examinations, procedures, therapies and treatments recommended by my healthcare provider(s), but would like to **AVOID the following complications and/or side effects:**

_____Reason_____
_____Reason_____
_____Reason_____
_____Reason_____

- ❑ I have attached additional pages as necessary

 Date_____ Person's Initials_____ Witness Initials_____ Witness Initials_____

Electro-Convulsive Treatment (check one)

- ❑ I do **NOT** consent to electroconvulsive treatment.
- ❑ I **consent** to the use of electroconvulsive treatment as deemed necessary by my treating physician.*
- ❑ If I have an agent, **I authorize my agent to consent*** to electroconvulsive treatment for me.*

*If consent to electroconvulsive treatment has been provided, the treating physician must still comply with the provisions of § 13-20-401, *et seq.*, COLO. REV. STAT. and all relevant regulations regarding the treatment and its administration. No part of this directive shall be a waiver of any rights or release of liability for negligence or other misconduct.

SECTION VI. SERVICES, ACTIVITIES AND ASSISTANCE

Sites for the delivery of behavioral health services include emergency rooms, acute treatment units, inpatient hospitalization, outpatient hospitalization, residential treatment centers, outpatient clinics or offices, behavioral health entities, and telepsychiatry.

Write your instructions for the preferred service below. Include alternative services you do or do not consent to when in need of treatment. Remember that there are a limited number of resources, and specific facilities must be willing and able to accept you at the time of need.

My preferred treatment facilities are:

_____

I prefer not to be treated at:

_____

My preferred treatment providers are:

_____

A. Upon my admission to inpatient treatment, I must immediately call and notify the following people:

Name_____ Phone_____

Name_____ Phone_____

Name_____ Phone_____

Name_____ Phone_____

- ❑ **I have completed a Delegation of Power by Parent or Guardian pursuant to § 15-14-105, C.R.S., for the care and custody of my dependents**.

B. Upon admission to inpatient treatment, the following people are allowed to visit me:

Name_____ Phone_____

Name_____ Phone_____

Name_____ Phone_____

Name_____ Phone_____

C. The following people are NOT allowed to visit me if I am admitted for inpatient treatment:

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

D. Other instructions:_____

_____

_____

- ❑ I have attached additional pages as necessary

 Date_____ Person's Initials_____ Witness Initials_____ Witness Initials_____

SECTION VII. ADDENDA

I have attached ____ (number) pages to this Form and I incorporate them as if they were a part of this directive in its entirety. Additional page template is provided at the end of this document.

*__Please have the PERSON and WITNESSES initial and date each additional page.__

SECTION VIII. HIPAA RELEASE STATEMENTS

Agent HIPAA RELEASE:	**Provider and Witness HIPAA RELEASE:**
By authorizing an agent, you give consent to the release of information about your entire health record for the duration of this Psychiatric Advance Directive (2 years), and for the agent to act as your Personal Representative. You understand such disclosure may include information relating to alcohol and drug use, mental health treatment, or HIV related information. ☐ Initials _____	I understand that my mental health treatment provider(s) may share this document, the information within it, or both, with my agent and with other providers as necessary to provide Continuity of Treatment in accordance with this PAD and applicable information privacy laws. I acknowledge and release to the Disinterested Witnesses that help me effect, amend, or revoke this form any and all information necessary for the disinterested witnesses to attest to my ability to make informed behavioral healthcare decisions. ☐ Initials _____

SECTION IX. AGENT APPOINTED FOR PSYCHIATRIC ADVANCE DIRECTIVE

For the Person using a Psychiatric Advance Directive:	**My agent may:**
❑ **I DO NOT** appoint an agent. ❑ I do appoint an agent.	❑ Execute my instructions only ❑ Make decisions concerning alternatives to my behavioral health treatment instructions and preferences.

❑ **If my primary agent is unable, unwilling, or incapable of serving as agent, I appoint a Successor agent to act for me regarding my Behavioral Health Treatment decisions.**

AGENT AGREEMENT:

By signing below, I indicate my willingness to act as agent for the Person completing this directive and am providing an exemplary signature. Once I have acted on behalf of the Person within the scope of authority granted above, I will continue to act in good faith, loyally for the Person's benefit, and within the scope of authority set forth in this document. I understand that if authority to make independent judgments on behalf of the Person is granted, I will be required to make informed decisions which may require seeking appropriate counsel or education from a qualified professional. I agree not to release private health information of the Person to any **unauthorized** third party at any time. I understand that I am under no obligation to financially support the Person's behavioral health instructions. If there are instructions to me from the Person that are not within the scope of Behavioral Health Treatment, a power of attorney conferring such authority may be necessary to accomplish those goals.

Primary Agent:	**Successor Agent:**
Name_____	Name_____
Phone _____	Phone _____
Address_____	Address_____
Signature_____	Signature_____
Date_____	Date_____

SECTION X. PERSON AND WITNESS SIGNATURE

THIS SECTION MUST BE COMPLETED TO MAKE THIS FORM VALID

PERSON'S DECLARATION:

By signing this Psychiatric Advance Directive under Colorado law, I declare that I am eighteen years of age or older, that I am not required to complete this directive to receive treatment or discount pricing, and that I have completed this directive in its entirety. My directive is _____ pages long (including attachments).

Sign:_____ Date: _____

THIS DIRECTIVE EXPIRES TWO YEARS FROM DATE SIGNED UNLESS AMENDED PRIOR TO EXPIRATION

WITNESS DECLARATION:

By signing this directive, I declare that I am a disinterested witness as defined below, that the Person executing, amending, or revoking this PAD is at least eighteen years old, is free from coercion, and is currently aware of the risks and consequences of the decisions made in this form.

Check the box next to your signature to attest to the Witness Declaration.

❑ EXECUTION	Print Name, Sign, and Date
❑ EXECUTION	Print Name, Sign, and Date
❑ AMEND / REVOKE (circle one)	Print Name, Sign, and Date
❑ AMEND / REVOKE (circle one)	Print Name, Sign, and Date

"DISINTERESTED WITNESS" means an adult other than a spouse, partner in a civil union, domestic partner, romantic partner, child, parent, sibling, grandchild, grandparent, health care provider, person who at the time of the adult's signature has a claim against any portion of the adult's estate at the time of the adult's death, or person who knows or believes that he or she has an entitlement to any portion of the adult's estate at the time of the adult's death either as a beneficiary of a will that exists at the time of the adult's signature or as an heir at law, who can attest that the adult executing the behavioral health orders form was of sound mind and free of coercion when he or she signed the behavioral health orders.