**Psychiatric Advance Directive (PAD)/Crisis Plan***
**New Jersey Advance Directives for Mental Health Care Act**
**NJSA 26: 2H-102 et seq.**

Name: D.O.B.: Phone:

Address:

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

**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.

**Please select and initial one of the following statements:**
_____ I can revoke this plan at any time as permitted by law.
_____ I do not wish to exercise my right to revoke this plan once it has been activated.

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

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

*Adapted from the Wellness and Recovery Action Plan (WRAP®) Crisis Plan. 

**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<br>Phone 2 |
|---|---|---|
| Name | Relationship to self | Phone 1<br>Phone 2 |
| Name | Relationship to self | Phone 1<br>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<br>Phone 2 |
|---|---|

**<u>Part 4.</u> 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 |
| 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 |
| 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 _____

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

_____This plan has been registered with the state of New Jersey.

**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 _____

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