Te Whatu Ora
Health New Zealand

ADVANCE DIRECTIVE/Whakaaro Pono
MENTAL HEALTH & ADDICTION SERVICES, Nelson Marlborough

A. My details

Name				
	Date of Birth		**NHI if known:**	
Current address				
Phone number	**Home:**		**Mobile:**	

B. Versions

I also have a video Advance Directive and this is a written summary	Yes ___ No ___

AND / OR

This Advance Directive has been	Date	Initials
Created on:		
Reviewed and confirmed:		
Reviewed and confirmed:		
Replaced by another Advance Directive:		
Cancelled:		

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SECTION 1: Services and Treatment

Think about location of treatment, types of treatments, cultural care, medications and alternative interventions that you do or do not want to have and explain why if you can. Consider what you have found useful in the past in reducing distress and aiding recovery when you are ill.

What I would like to have happen:
What I would **NOT** like to have happen:

SECTION 2: Having staff and family/whānau/friends involved in my care or treatment

In an **emergency** contact: *(include name and phone numbers for your emergency contact person)*
If someone is needed to make decisions on my behalf it is:

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I **do** / **do not** have a formal **Power of Attorney**
People I **DO** want included in my care:
People I **DO NOT** want to include in my care:

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SECTION 3: Management of Personal Affairs

Consider any needs and wishes you have regarding children (consider completion of a children's care plan), work, household, pets/animals, physical health needs

SECTION 4: Additional Information

Add any other important information that others should know

Plans that support my recovery:
Plans that prevent my recovery:
Other: *(e.g. physical health needs, triggers, other relevant documents…)*

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SECTION 5: What is to happen if this Advance Directive is not followed?

If this Advance Directive is not followed, I want an explanation verbally & in writing, to be given to:

☐ Me ☐ My family/whānau ☐ Others:_____

SECTION 6: Verification of my informed Advance Directive

This Advance Directive outlines my preferences for mental health treatment & care options **if** I am unable to communicate these because of mental illness. I have written it of my own free will and I have sufficient information to make these requests. I understand that, in some circumstances, not all my preferences will be able to be acted on, but I want my clinical team to understand these are important to me.

The registered health professional that has assessed me as competent (of sound mind) at this date is:

Name		**Designation**	
Signature		**Date**	

Support Person: Care Manager / Other health kaimahi *(e.g. consumer advocate)*

I have helped _____ prepare this Advance Directive and believe this is a true reflection of their preferences

Name			
Signature			
Designation		**Date:**	

My Mental Health Advance Directive (AD) is in place until stated otherwise on page 1.

Name			
Signature		**Date**	