Attachment D: Capital Area Human Services District
Adult Medical Preferences

Date: _____________ Client: ___________________________________D.O.B.: _________________

I, the undersigned, a client of____ (CAHSD Clinic/Program), hereby authorize the staff of this organization to act in accordance with the preferences listed below. I understand that there are circumstances when my directives or preferences cannot be honored or are not in my best interest. In those instances, I authorize the staff to act in accordance with the applicable laws and regulations.

1. I authorize the staff of the organization to contact the following family members/others in the event of an emergency:
   ____
   ____
   ____

2. In the event of my transfer to a psychiatric or medical treating facility my preference is to be transferred to:

   _____ Our Lady of the Lake Regional Medical Center

   _____ Baton Rouge General Medical Center

   _____ Other ____

   I understand in some circumstances I will be transported to another treating facility.

3. Advanced Directives (A form documenting a patient's right to control decisions concerning his or her own medical care, in collaboration with his or her physician):

   I have a Louisiana Advance Directive for Mental Health Treatment.

   ________Yes ________No

   ________If yes, I have provided a signed and dated true copy to be included in my medical record, so that the Advance Directive for Mental Health Treatment is now operative.

   ________If yes, I will provide a signed and dated copy to be included in my medical record, and I understand that the Advance Directive for Mental Health Treatment will not be operative until I do so.

   ________If no, I have been offered and I accept the written packet of information and forms for the Louisiana Advance Directive for Mental Health Treatment.

   ________If no, I have been offered and I declined the written packet of information and forms for the Louisiana Advance Directive for Mental Health Treatment.

_____ I have submitted copies of the following Advanced Directives:

_____ Medical _____ Behavioral

_____ I have no Advanced Directives on file

I hereby certify I have read this Client Preferences/Directives form and have completed the form to the best of my ability and understand the authorization has been explained to me and I understand the authorizations I have given herein.

Client/Guardian Signature: ____ Date: ___________

Client Representative Signature: ____ Date: ___________
(If applicable)

Witness Signature: ____ Date: __________

_____Client/Guardian declined to complete the Medical Preferences form.

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