Declaration for Mental Health Treatment

Attention:
This advanced medical directive is a legal document which provides *Consent to Treatment* for mental health treatment. It contains important information regarding the affected person's wishes for mental health care.

NOTICE TO PERSON MAKING A DELCLARATION FOR MENTAL HEALTH TREATMENT

This is an important legal document. It creates a declaration for mental health treatment. Before signing this document, you should know these important facts:

This document allows you to make decisions in advance about three types of mental health treatment: psychoactive medication, convulsive therapy and short-term (up to 17 days) admission to a treatment facility. The instructions that you include in this declaration will be followed only if a court or two physicians believe that you are incapable to give or withhold consent for the treatments.

You may also appoint a person as your attorney-in-fact to make these treatment decisions for you if you become incapable. The person you appoint has a duty to act consistent with your desires as stated in this document or, if your desires are not stated or otherwise made known to the attorney-in-fact, to act in a manner consistent with what the person in good faith believes to be in your best interest. For the appointment to be effective, the person you appoint must accept the appointment in writing. The person also has the right to withdraw from acting as your attorney-in-fact at any time.

This document will continue in effect for a period of three years unless you become incapable of participating in mental health treatment decisions. If this occurs, the directive will continue in effect until you are no longer incapable.

You have the right to revoke this document in whole or in part at any time you have not been determined to be incapable. ***YOU MAY NOT REVOKE THIS DECLARATION WHEN YOU ARE CONSIDERED INCAPABLE BY A COURT OR TWO PHYSICIANS.*** A revocation is effective when it is communicated to your attending physician or other provider.

If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you. This declaration will not be valid unless it is signed by two qualified witnesses who are personally known to you and who are present when you sign or acknowledge your signature.

Declaration for Mental Health Treatment

I, _____, being an adult of sound mind, willfully and voluntarily make this declaration for mental health treatment to be followed if it is determined by a court or by two physicians that my ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that I lack the capacity to refuse or consent to mental health treatment. "Mental health treatment" means convulsive treatment, treatment of mental illness with psychoactive medication, and admission to and retention in a health care facility for a period up to 17 days.

I understand that I may become incapable of giving or withholding informed consent for mental health treatment due to the symptoms of a diagnosed mental disorder. These symptoms may include:

_____

_____

_____

PSYCHOACTIVE MEDICATIONS

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding psychoactive medications are as follows:

_____ I consent to the administration of the following medications:

_____

_____

_____ I do not consent to the administration of the following medications:

_____

_____

Conditions or limitations: _____

_____

CONVULSIVE TREATMENT

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding convulsive treatment are as follows:

_____ I consent to the administration of convulsive treatment.

_____ I do not consent to the administration of convulsive treatment.

Conditions or limitations: _____

_____

ADMISSION TO AND RETENTION IN FACILITY

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding admission to and retention in a health care facility for mental health treatment are as follows:

_____ I consent to being admitted to a health care facility for mental health treatment.

_____ I do not consent to being admitted to a health care facility for mental health treatment.

This directive cannot, by law, provide consent to retain me in a facility for more than 17 days.

Conditions or limitations: _____

_____

ADDITIONAL REFERENCES OR INSTRUCTIONS

_____

_____

Conditions or limitations: _____

_____

ATTORNEY-IN-FACT

I hereby appoint:

NAME: _____

ADDRESS: _____

_____

TELEPHONE# _____

to act as my attorney-in-fact to make decisions regarding my mental health treatment if I become incapable of giving or withholding informed consent for that treatment.

If the person named above refuses or in unable to act on my behalf, or if I revoke that person's authority to act as my attorney-in-fact, I authorize the following person to act as my attorney-in-fact:

NAME: _____

ADDRESS: _____

_____

TELEPHONE# _____

My attorney-in-fact is authorized to make decisions that are consistent with the wishes I have expressed in this declaration or, if not expressed, as are otherwise known to my attorney-in-fact. If my wishes are not expressed and are not otherwise known by my attorney-in-fact, my attorney-in-fact is to act in what he or she believes to be my best interests.

You must sign here for this document to be effective ☞ _____

(Signature of Principal/Date)

AFFIRMATION OF WITNESSES

We affirm that the principal is personally known to us, that the principal signed or acknowledged the principal's signature on this declaration for mental health treatment in our presence, that the principal appears to be of sound mind and not under duress, fraud or undue influence, that neither of us is:

- A person appointed as an attorney-in-fact by this document.
- The principal's attending physician or mental health service provider or a relative of the physician or provider;\
- The owner, operator or relative of an owner or operator of a facility in which the principal is a patient or resident; or
- A person related to the principal by blood, marriage or adoption.

(Signature of Witness/Date)	(Printed name of Witness)
(Signature of Witness/Date)	(Printed name of Witness)

ACCEPTANCE OF APPOINTMENT AS ATTORNEY-IN-FACT

I accept this appointment and agree to serve as attorney-in-fact to make decisions about mental health treatment for the principal. I understand that I have a duty to act consistent with the desires of the principal as expressed in this appointment. I understand that this document gives me authority to make decisions about mental treatment only while the principal is incapable as determined by a court or two physicians. I understand that the principal may revoke this declaration in whole or in part at any time and in any manner when the principal is not incapable.

(Signature of Attorney-in-Fact/Date)	(Printed name)
(Signature of Attorney-in-Fact/Date)	(Printed name)