

NOTICE
TO PERSON MAKING
A DECLARATION 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: psychotropic medication, electroconvulsive 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 two physicians or a judge believes that you are incapable of making treatment decisions. Otherwise, you will be considered capable 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 declaration will not be valid unless it is signed by you and by two qualified witnesses who are personally known to you and who are present when you sign or acknowledge your signature.

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 been determined by a physician to be capable of giving or withholding informed consent for mental health treatment. A revocation is effective when it is communicated to your attending physician in writing and is signed by you and a physician.

If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

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 two physicians or the court 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 electroconvulsive therapy, psychotropic medication, and admission to and retention in a health care facility for up to 17 days for treatment of a mental illness

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:

PSYCHOTROPIC MEDICATIONS

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding psychotropic medications are as follows (check the option that applies):

I consent to the administration of psychotropic medications.

I consent to the administration of psychotropic medications except the following:

I consent to the administration of only the following psychotropic medications:

I do not consent to the administration of any psychotropic medications.

Conditions or limitations:

ELECTROCONVULSIVE TREATMENT

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding electroconvulsive treatment are as follows (check the option that applies):

_____ I consent to the administration of electroconvulsive treatment.

_____ I do not consent to the administration of electroconvulsive 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 (check the option that applies):

_____ I 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.)

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

Conditions or limitations:

APPOINTMENT OF ATTORNEY-IN-FACT

I appoint the person named below 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. 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 interest.

Name _____

Address _____

Telephone _____

If this person refuses or is 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 _____

ACCEPTANCE OF APPOINTMENT AS ATTORNEY-IN-FACT

I accept this appointment and agree to serve as attorney-in-fact to make decisions a bout 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 health 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 Alternate Attorney-in-fact/Date)

(Printed Name)

SELECTION OF PHYSICIAN

If it becomes necessary to determine if I have become incapable of giving or withholding informed consent for mental health treatment, I choose the doctor named below to be one of the two physicians who will determine whether I am incapable. If that physician is unavailable, that physician's designee shall determine whether I am incapable.

Name _____

Address _____

Telephone _____

ADDITIONAL INSTRUCTIONS OR CONDITIONS

(Signature of Principal/Date)

(Printed Name of Principal)

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)

REVOCATION

I understand that I have the right to revoke this document in whole or in part at any time that I have been determined by a physician to be capable of giving or withholding informed consent for mental health treatment. A revocation is effective when it is communicated to my attending physician in writing and is signed by both a physician and me.

I, _____, willfully and voluntarily revoke my declaration for mental health treatment as indicated:

_____ I revoke my entire declaration.

_____ I revoke the following portion of my declaration:

(Signature of Principal/Date)

I, the undersigned physician, have evaluated the principal and determined that he or she is capable of giving or withholding informed consent for mental health treatment.

(Signature of Physician/Date)

(Printed name)