DECLARATION FOR MENTAL HEALTH TREATMENT

I, _____, being an adult of sound mind,

(printed name)

willfully and voluntarily make this declaration for mental health treatment to be followed if it is determined by 2 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 treatment, treatment of mental illness with psychotropic medication, and admission to and retention in a health care facility for mental treatment for a period of 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:

PSYCHOTROPIC MEDICATIONS

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

☐ I consent to the following medications:

☐ I do not consent to the following 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:

☐ 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 and *retention in a mental health facility 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 facility for mental health treatment.

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

Conditions or limitations:

SELECTION OF PHYSICIAN (OPTIONAL)

If it becomes necessary to determine if I have become incapable of giving or withholding informed consent or mental health

treatment, I choose Dr. _____ of _____

to be one of the 2 physicians who will determine whether I am incapable. If that physician is unavailable, that physician's designee shall determine whether I am incapable.

ADDITIONAL REFERENCES OR INSTRUCTIONS

Conditions or limitations:

ATTORNEY-IN-FACT

I hereby appoint:

NAME _____

ADDRESS _____

(street) (city) (state) (zip) (telephone number)

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 refused 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 to act as my attorney-in-fact:

NAME _____

ADDRESS _____

(street) (city) (state) (zip) (telephone number)

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, 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.

_____ _____

(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 presense, 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 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.

Witnessed by:

(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 my authority to make decisions about mental health treatment only while the principal is incapable as determined by a court or 2 physicians. I understand that the principal may revoke this declaration at any time and in any manner when the principal is not incapable.

(Signature of witness)	(Date)	(Printed name of witness)
(Signature of witness)	(Date)	(Printed name of witness)

REVOCATION OF DECLARATION FOR MENTAL HEALTH TREATMENT

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

☐ I revoke my entire declaration

☐ I revoke the following portion of my declaration:

Date: _____ Signed: _____
(Signature of principal)

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

Date: _____ Signed: _____
(Signature of principal)

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 2 qualified witnesses who are personally known to you and who are present when you sign or acknowledge your signature.

I provided the above - named individual with a copy of this Revocation in ☐ English ☐ Spanish
☐ Other _____ at the individual's request.
(Specify)

_____ _____ on _____
Name Title Date