MENTAL HEALTH CARE DECLARATION FORM

I,____, having capacity to make mental health decisions, willfully and voluntarily make this Declaration regarding my mental health care. I understand that mental health care includes any care, treatment, service or procedure to maintain, diagnose, treat or provide for mental health, including any medication program and therapeutic treatment. Electroconvulsive therapy may be administered only if I have specifically consented to it in this document. I will be the subject of laboratory trials or research only if specifically provided for in this document. Mental health care does not include psychosurgery or termination of parental rights. I understand that my incapacity will be determined by examination by a psychiatrist and one of the following: another psychiatrist, psychologist, family physician, attending physician or mental health treatment professional. Whenever possible, one of the decision makers will be one of my treating professionals.

A. When this Declaration becomes effective

This Declaration becomes effective at the following designated time:

☐ When I am deemed incapable of making mental health care decisions. I would prefer the following doctor(s) to evaluate me for my ability to make mental health decisions:

Name of Doctor: ____

Address/Phone Number: ____

☐ When the following condition is met: (List condition)________________________________

B. Treatment preferences

1. Choice of treatment facility.

☐ In the event that I require commitment to a psychiatric treatment facility, I would prefer to be admitted to the following facility:

Name of facility: ____

Address: ____

City, State, Zip Code: ____

☐ In the event that I require commitment to a psychiatric treatment facility, I do not wish to be committed to the following facility:

Name of facility: ____

Address: ____

City, State, Zip Code: ____

I understand that my physician may have to place me in a facility that is not my preference.

2. Preferences regarding medications for psychiatric treatment.

☐ I consent to the medications that my treating physician recommends.

☐ I consent to the medications that my treating physician recommends with the following exceptions, limitations and/or preferences:

Medication	Reason for Exception
______________	______________________________
______________	______________________________
______________	______________________________

I consent to the following medications with these limitations:

Medication	Limitation	Reason for Limitation
______________	____________	______________________
______________	____________	______________________
______________	____________	______________________

I prefer the following medications:

Medication	Reason for Preference
______________	______________________________
______________	______________________________
______________	______________________________

The exception, limitation, or preference, applies to generic, brand name and trade name equivalents unless otherwise stated. I understand that dosage instructions are not binding on my physician.

☐ I do not consent to the use of any medications.

3. Preferences regarding electroconvulsive therapy (ECT).

☐ I consent to the administration of electroconvulsive therapy.

☐ I do not consent to the administration of electroconvulsive therapy.

4. Preferences for experimental studies.

☐ I consent to participation in experimental studies if my treating physician believes that the potential benefits to me outweigh the possible risks to me.

☐ I do not consent to participation in experimental studies.

5. Preferences for drug trials.

☐ I consent to participation in drug trials if my treating physician believes that the potential benefits to me outweigh the possible risks to me.

☐ I do not consent to participation in any drug trials.

6. Additional instructions or information.

Examples of other instructions or information that may be included:
Activities that help or worsen symptoms:

____

____

____

____

Type of intervention preferred in the event of a crisis:

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Mental and physical health history:

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Dietary requirements:

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Religious preferences:

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Temporary custody of children:

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Family notification:

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Limitations on the release or disclosure of mental health records:

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Temporary care and custody of pets:

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Other matters of importance:

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C. Revocation and Amendments

This Declaration may be revoked in whole or in part at any time, either orally or in writing, as long as I have not been found to be incapable of making mental health decisions. My revocation will be effective upon communication to my attending physician or other mental health care provider, either by me or a witness to my revocation, of the intent to revoke. If I choose to revoke a particular instruction contained in this Declaration in the manner specified, I understand that the other instructions contained in this Declaration will remain effective until:

(1) I revoke this Declaration in its entirety;
(2) I make a new Mental Health Advance Directive; or
(3) Two years after the date this document was executed.

I may make changes to this Advance Directive at any time, as long as I have capacity to make mental health care decisions. Any changes will be made in writing and be signed and witnessed by two individuals in the same way the original document was executed. Any changes will be effective as soon the changes are communicated to my attending physician or other mental health care provider, either by me or a witness to my amendments.

D. Termination

I understand that this Declaration will automatically terminate two years from the date of execution, unless I am deemed incapable of making mental health care decisions at the time that this Declaration would expire.

E. Preference as to a court-appointed guardian

I understand that I may nominate a guardian of my person for consideration by the court if incapacity proceedings are commenced under 20 Pa.C.S. § 5511. I understand that the court will appoint a guardian

in accordance with my most recent nomination except for good cause or disqualification. In the event a court decides to appoint a guardian, I desire the following person to be appointed:

Name of Person: ____

Address: ____

City, State, Zip Code:____

Phone Number: __________- __________- _____________

☐ The appointment of a guardian of my person will not give the guardian the power to revoke, suspend or terminate this Declaration.

☐ Upon appointment of a guardian, I authorize the guardian to revoke, suspend or terminate this Declaration.

F. Execution

I am making this Declaration on the ________ day of _____________, _______________.
month year

My Signature: ____

My Name: ____

Address: ____

City, State, Zip Code: ____

Phone Number: __________- __________- _____________

_______________________________________ _______________________________________
Witness Signature Witness Signature

Name of Witness: ____

Address: ____

City, State, Zip Code: ____

Phone Number: __________- __________- _____________

Name of Witness:____

Address:____

City, State, Zip Code:____

Phone Number: __________- __________- _____________

If the principal making this Declaration is unable to sign it, another individual may sign on behalf of and at the direction of the principal.

Signature of person signing on my behalf: ____

Name of Person:____

Address: ____

City, State, Zip Code: ____

Phone Number: __________- __________- _____________

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