Advance Directive for Mental Health Treatment

This document is to be used as an example only. Please contact your state's Protection and Advocacy Program, a lawyer, paralegal, or advocate to create a legally binding document.

My Name: _____

Symptoms that tell me I may not be capable of making decisions for myself:

- _____
- _____
- _____
- _____

I appoint the following person to act as my representative to make decisions about my mental health care if I become incapable:

Name: _____

Address: _____

_____

Phone: _____

If the above person is not available or refuses to act on my behalf, the following person can act on my behalf:

Name: _____

Address: _____

_____

Phone: _____

While in a treatment facility, I agree to take the following medication(s):

_____

_____

_____

_____

_____

While in a treatment facility, I DO NOT agree to take the following medication(s): (consider giving reasons)

_____

_____

_____

_____

_____

List any allergies, known side effects, or other medical conditions:

_____

_____

_____

_____

_____

In the event I need to be hospitalized, my preferred treatment facilities are (in order of preference):

- _____
- _____

- _____

I DO NOT want to be treated at the following facilities:
(consider giving reasons)

- _____
- _____
- _____

List the names and contact information for your mental health treatment team:

Psychiatrist Name: _____

Psychiatrist Phone: _____

Therapist Name: _____

Therapist Number: _____

Case Manager Name: _____

Case Manager Phone: _____

Other names and numbers: _____

_____

_____

I give permission for the following people to visit me in the treatment facility:

_____

_____

_____

_____

_____

Treatment facility staff can help me by doing the following:

_____

_____

_____

_____

_____

Please check one of the following:

_____ I give consent to receive Electric Shock Therapy (ECT).

_____ I DO NOT give consent to receive Electric Shock Therapy (ECT).

Are there other special considerations you need while being treated?
(Consider including any other illnesses you may have, any dietary restrictions, or other matters of concern.)

_____

_____

_____

_____

_____

While I am being treated, the following things will need to be taken care of at my home:

_____

_____

_____

_____

_____

The following people may be given information about my condition and treatment(s):

_____

_____

_____

_____

_____

_____ _____

Signature of patient **Printed Name and Date**

_____ _____

Signature of witness **Printed Name and Date**

_____ _____

Signature of witness **Printed Name and Date**

_____ _____

Signature of health care provider **Printed Name and Date**