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