

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