

## **Mental Health Declaration**

I, \_\_\_\_\_, having the 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.
  
- ( ) 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:

*(Insert name and address of facility)*

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

*(Insert name and address of facility)*

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 with the following exception, preference or limitation:

*(List medication and reason for exception, preference or limitation)*

This exception, preference or limitation applies to generic, brand name and trade name equivalents. 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 or drug trials.**

- ( ) 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.

- ( ) 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.

**5. 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.
- Mental and physical health history.
- Dietary requirements.
- Religious preferences.
- Temporary custody of children.
- Family notification.
- Limitations on the release or disclosure of mental health records.
- Other matters of importance.

**C. Revocation.**

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 care declaration; or
- (3) two years after the date this document was executed.

**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 the 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 pursuant to 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:

*(Insert name, address and telephone number of designated person)*

- ( ) 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.

I am making this declaration on the *(insert day)* day of *(insert month)*, *(insert year)*.

My signature: *(My name, address, telephone number)*

Witnesses' signatures: *(Names, addresses, telephone numbers of witnesses)*

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, address and telephone number)*