ADVANCE DIRECTIVE FOR MENTAL HEALTH TREATMENT

I, _____, willfully and voluntarily execute this advance directive for mental health treatment. I want the instructions in this advance directive to be followed as described below.

Designated Surrogate

_____ I am naming a surrogate to see that my instructions for mental health treatment are carried out.

I designate _____ to act as my surrogate. If this person withdraws or is unwilling to act on my behalf, or if I revoke that person's authority to act as my surrogate, I designate _____ to act as my alternate surrogate.

The person acting as my surrogate is authorized to act in accordance with the content of this advance directive and may override the advance directive if, and only if, there is substantial medical evidence that failing to do so would result in harm to me. If my instructions and preferences are not stated in the advance directive, the surrogate may act in good faith in making treatment decisions in the manner in which the surrogate believes I would act.

_____ I am not naming a surrogate to see that my instructions for mental health treatment are carried out.

If I do not designate a surrogate, if my surrogate and alternate surrogate withdraw or are unwilling to act on my behalf, or if I revoke their authority to act, then the health care provider and health care facility may proceed to render treatment in accordance with my instructions as described here and in accordance with standards for mental and physical health care.

Psychotropic Medication Provisions

I may indicate below any refusals of treatment with specific psychotropic medications, not to include an entire class of medications, due to factors that may include but are not limited to lack of efficacy, known drug sensitivity, or experience of adverse reaction:

I specifically do not consent and do not authorize my surrogate to consent to the administration of the following medications or their respective brand-name or generic equivalents for the reasons given:

Specific psychotropic medication	Reason for refusal
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I may list below any specific psychotropic medications that I would be willing to have administered to me if additional medications become necessary:

Specific psychotropic medications:

_____	_____
_____	_____

Electroconvulsive Therapy Provisions

Below are my instructions regarding electroconvulsive therapy (ECT):

_____ I consent to electroconvulsive therapy (ECT) if it is deemed clinically appropriate to treat my condition.

_____ I do not consent to electroconvulsive therapy (ECT).

Preferred Procedures for Emergency Interventions

I may state preferences for procedures for emergency interventions to be used when necessary for my protection or the protection of others. I understand that I am requesting consideration of my preferences for procedures for emergency interventions but that my surrogate, my health care provider, and the health care facility where I am a patient are not subject to civil liability for not abiding by these preferences. I understand that in the case of possible harm to myself or others, my health care provider or the health care facility may need to use procedures that override my stated preferences. If during an admission or while a patient in a health care facility, it is determined that I am engaging in behavior that requires emergency intervention, my preferences regarding the procedures to be used during an emergency intervention and the order that I prefer the interventions to be used are as follows:

Intervention	***Order of Preference***	***Reason for preference***
Seclusion		
Physical restraints		
Seclusion & physical restraint combined		
Medication by injection		
Medication in pill form		
Liquid medication		
Other		
Other		

Signed this _____ day of _____, 20_____

Signature of grantor: _____

Address of grantor: _____

_____

In my presence, the grantor voluntarily dated and signed this writing or directed it to be dated and signed. I am not the grantor's current health care provider, a relative of the current health care provider, or an owner, operator, employee or relative of an owner or operator of a health facility in which the grantor is a client or resident.

Signature of witness: _____

Signature of witness: _____

Surrogate contact information (if designated):

Name: _____

Address: _____

_____

Telephone: _____

Signed this ____ day of_____,

20_____.

Signature of surrogate:

_____

Alternate surrogate contact information (if designated):

Name: _____

Address: _____

_____

Telephone: _____

Signed this ____ day of_____,

20_____.

Signature of surrogate:

_____