

## **Directions for using the Combined Mental Health Advance Directive Declaration and Power of Attorney form.**

1. Read each section very carefully.
2. By using the combination form you will be giving or withholding consent related to some specific mental health treatments and also designating a person to act as your agent for giving consent for other treatment options. Mark your preference in each section with your initials. Although you do not have to explain your choices, it is helpful if you include statements explaining why you want or don't want any specific treatments. If any of your choices are challenged, you will have a better chance of having your choice honored if a court understands what your reasons are for making your choice.
3. Your document must be signed and dated by you and your agent in the presence of two witnesses. Each witness must be at least 18 years old. If you are unable to sign the document yourself, you may have someone else sign on your behalf, but that person may not also be a witness.
4. You are presumed to be capable of making an advance directive unless you have been adjudicated incapacitated, involuntarily committed, or found to be incapable of making mental health decisions after examination by both a psychiatrist and another doctor or mental health professional.
5. Remember that just because you consent in advance to a particular medication or treatment, that your doctor will not prescribe that treatment or drug unless it is appropriate treatment at the time you are ill. Consent only means that you consent if it is a suitable choice *at that time* within the standards of medical care. Your doctor will also have to consider if a particular treatment option is covered by your insurance. If, for example, the HMO that you have does not cover a certain drug on its formulary, your doctor may prescribe a drug that is similar, but is on the HMO formulary.
6. If there are no instructions about a specific treatment in your declaration, your agent will make decisions on your behalf. If you wish to allow your agent to be able to consent to electroconvulsive therapy and/or experimental procedures or research on your behalf you must expressly mark your those sections in your directive. **If you do not mark the related sections your agent will not be allowed to consent to electroconvulsive therapy and/or experimental procedures or research.** Your agent will try to make the decision that you would have made for yourself. That is why it is very important that you share your thoughts and feelings about treatment with your agent.
7. In order for your directive to be effective, you must be sure that the right people have access to your advance directive. Give copies to your doctor, family members, and/or other support people that may be notified if you become ill. Remember that if you cancel or change your document you must let everyone know. It is a good idea to carry a card in your wallet to let people know that you have an advance directive.

To Use the Form:

## **Part I. Introduction.**

1. Print your name in the blank in the introductory paragraph at the top of the page.

### **A. When this Declaration becomes effective.**

Decide when you want the declaration to become effective. You can specify a condition, such as if you are involuntarily committed for either outpatient or inpatient care, or some other behavior or event that you know happens when you no longer have capacity to make mental health decisions, or you can specify that you want an evaluation for incapacity.

If you do not choose a condition, your incapacity will be determined after examination by a psychiatrist and one of the following: another psychiatrist, psychologist, family physician, attending physician, or other mental health treatment professional. If you have doctors that you would prefer to make the evaluation, you should specify them in your declaration. Although that doctor may not be available, an effort will at least be made to contact them.

Until your condition is met, or you are found to be unable to make mental health decisions, you will make decisions for yourself.

### **B. Revocation and Amendments.**

Revocation means that you are canceling your mental health advance directive. If you revoke your directive, your doctor will no longer have to follow the instructions that gave in the document, or follow instructions given by your agent. You may revoke your directive at any time, as long as you have capacity to make mental health decisions. You may revoke a specific instruction without revoking the entire document.

If you have been involuntarily committed, and you want to change or revoke your mental health advance directive, you will need to request an evaluation to determine if you are capable of making mental health decisions. The evaluation will be done by both a psychiatrist and another psychiatrist, psychologist, family physician, attending physician or other mental health professional. If you are found to have the capacity to make mental health decisions, you will be able to revoke or change your directive, even though you are in the hospital.

You may revoke your mental health advance directive orally or in writing. Your advance directive will terminate as soon as you communicate your revocation to your treating doctor. It is best to make any changes or revocation in writing, because then there is a clear record of your wishes.

If you make a new mental health advance directive, you should be sure to notify your doctor and support people that you have revoked the old one. Your advance directive will automatically expire two years from the date you made it, unless you are unable to make mental

health decisions for yourself at the time it would expire. In that case, it will remain in force until you are able to make decisions for yourself.

To amend your advance directive means that you make changes to it. You may make changes at any time, as long as you have capacity to make mental health care decisions. Any changes must be made in writing and be signed and witnessed by two individuals in the same way the original document was executed. Any changes will be effective as soon as the changes are communicated to your attending physician or other mental health care provider, either by you, your agent, or a witness to your amendments.

### **C. Termination.**

Your advance directive will automatically expire two years from the date of execution, unless you have been found incapable of making mental health care decisions at the time the directive would expire. In that case, the directive will continue to be in force until you regain capacity.

## **Part II. Mental Health Declaration.**

### **A. Treatment Preferences.**

#### **1. Choice of treatment facility.**

If you have a preference for or bad feelings toward any particular hospital, list them here. Unfortunately there are times when a particular place is already full and would be unable to accommodate you, or the treating doctor does not have privileges at the hospital you would prefer. Therefore, although your doctor will try to respect your choice, it may not always be possible.

#### **2. Medications.**

If you give instructions about medications, be sure to give reasons for your decisions. If, for instance, you experienced unacceptable side effects from a particular generic or dose, you would want to be specific so that your treating doctor understands your concern. That way your doctor will be less likely to prescribe something else that is likely to cause similar problems. Likewise, if you know that a specific medication has worked for you in the past, you should be sure to include that information. If a time-released version works, but the regular brand does not, you should be sure you include that information. The more your doctor knows about you, the more likely you are to get the right treatment, faster.

Be careful what you specify. Medications come in brand and generic names, and also belong to broader classes of drugs, such as “atypical antipsychotics” or “SSRIs.” If you rule out an entire class of drugs, you should be aware that a new, helpful drug may come on the market that could be ruled out, even though you don’t actually know anything about it.

You may choose to let your agent make decisions related to the use of medications. If you choose this option, be sure to discuss your feelings and prior experiences with medication with your agent.

You may choose not to consent to the use of any medications. Just be aware that you will also be ruling out new medications that could be helpful in your treatment. Your advance directive may also be challenged if your doctor believes that you will be irreparably harmed by this choice.

### **3. Preferences related to electroconvulsive therapy (ECT).**

In some cases, a doctor may find that ECT would be an effective form of treatment. If you have found ECT helpful in the past, or you trust your doctor to make that decision on your behalf, you may decide to consent to this treatment in advance.

You may choose to let your agent make decisions related to ECT. If you choose this option, be sure to discuss your feelings and prior experiences with ECT with your agent. **NOTE: Your agent is NOT allowed to consent to ECT unless you initial this authorization.**

If you do not wish to undergo ECT under any circumstances, you should initial the line next to “I do not consent to the administration of electroconvulsive therapy.”

### **4. Preferences for experimental studies.**

Opportunities may exist for you to participate in experimental studies related to treatment of your illness. Sometimes these studies provide more data that helps doctors determine the cause or best practice for treating an illness. Sometimes the studies are based on the idea that a certain new treatment might help. If you participate in a study, you may have access to a new treatment sooner than you would otherwise. However, there may be some level of risk involved. If you want to participate in a study if your doctor believes that the potential benefits to you outweigh the potential risks, you should initial the first choice.

You may choose to let your agent make decisions related to your participation for experimental studies. It is important that your agent understand the kind of studies that you would object to. For example, you may wish to participate only if the study does not include medication or any invasive procedures. **NOTE: Your agent is NOT allowed to consent to experimental studies unless you initial this authorization.**

If you do not want to participate in experimental studies of any kind, under any circumstances, you should initial the choice that states that you do not consent.

### **5. Preferences regarding drug trials.**

Similarly, you may have the opportunity to participate in a trial related to new medications. If you participate, you may have access to a new drug sooner than you would

otherwise. However, there may be risks or side effects. If you want to participate in a drug trial if your doctor believes that the potential benefits to you outweigh the potential risks, you should initial the first choice.

You may choose to let your agent make decisions related to your participation in drug trials. It is important that your agent understand any particular risks that you would not be willing to take so that he/she can make the decision you would make given the same information. **NOTE: Your agent is NOT allowed to consent to research including drug trials unless you initial this authorization.**

If you do not want to participate in a drug trial of any kind, under any circumstances, you should initial the choice that states that you do not consent.

#### **6. Additional instructions or information.**

One of the significant benefits of filling out an advance directive is that you are communicating important information to your mental health care provider, agent, and others who support you. This part of your form allows you to provide information that may or may not be directly related to your mental health treatment. If there is other information that you would like your mental health care provider and agent to know, you should include it here. You can attach an additional page to the form if there is not enough room to write everything you need to. Just be sure that you print or type your statements, and try to make them as clear as possible, to minimize confusion about what you want to happen. If you do not have a preference about something listed, or you are comfortable letting your agent make that particular decision, just leave that particular section blank.

### **Part III. Mental Health Power of Attorney.**

**1.** Print your name in the blank in the first paragraph stating that you are authorizing a designated health care agent to make certain decisions on your behalf.

#### **A. Designation of Agent.**

You may name any adult who has capacity as your agent, with the following exceptions: your mental health care provider or an employee of your mental health care provider or an agent, operator, or employee of a residential facility in which you are receiving care may not serve as your agent unless they are related to you by marriage, blood or adoption.

Write in the name of the person you choose, and fill in their address and phone number. You want the person to be contacted anytime, so add as much information as possible, including work and home phone numbers. The person that you choose as your agent should also sign the document to indicate that he/she accepts serving as your agent.

Since your agent will be making decisions on your behalf, it is very important to choose someone you trust and to discuss your ideas and feelings in detail so that the person really understands what mental health decisions you would have made for yourself.

## **B. Designation of an Alternative Agent.**

You may wish to designate an alternative person in case the first person you chose is unavailable. This is a good idea if you have another person that you trust, since people may be unavailable for a variety of reasons such as illness or travel. If you do not have any one that you wish to name as an alternative, leave this section blank.

The person that you choose as your alternative agent should also sign the document to indicate that he/she accepts serving as your agent. Your alternative agent must fill in his/her address and phone number so that they can be reached by your provider.

## **C. Authority Granted to Agent.**

You may grant full power and authority to your agent to make all of your mental health care decisions, or you can set limits on the kinds of decisions your agent may make on your behalf. If you wish to limit the decisions your agent can make you should read each subsection carefully and initial your choice. Your agent cannot consent to electroconvulsive therapy, experimental procedures or research unless you expressly grant those powers by initialing consent in those sections. If there is some other mental health care decision that you do not want your agent to be able to make, you may write it in. Be sure to write clearly, so there is no room for confusion.

The Pennsylvania law does not allow your agent to consent to psychosurgery or the termination of parental rights on your behalf, even if you are willing for your agent to have that power.

## **PART IV. Nominating a Guardian.**

### **A. Preference as to a court-appointed guardian.**

If you become incapacitated, it is possible that a court may appoint a guardian to act on your behalf. Under the guardianship laws, you may nominate a guardian of your person for consideration by the court. The court will appoint your guardian in accordance with your most recent nomination except for good cause or disqualification. If you wish to name someone in your power of attorney, it is important that you talk to that person about whether they feel they can serve as your guardian, because a court will not force them to serve. It is also important that you give that person a copy of your power of attorney and explain your wishes regarding mental health treatment.

If the court appoints a guardian, that person will not be able to terminate, revoke or suspend your power of attorney unless you want them to be able to. In this section, you should

decide whether you want a court appointed guardian to have that power. Even if you do not specify a person that you would want as a guardian, you can still specify whether a person that is appointed by the court is allowed to terminate, revoke or suspend your declaration.

If the court-appointed guardian and your agent turn out to be different people, the court will give preference to allowing your mental health care agent to continue making mental health care decisions as provided in your directive, unless you specify otherwise in your directive. If, after thorough examination, the court decides to grant the powers that you gave to an agent to the guardian, the guardian would still be bound by the same obligations that your agent would have been.

## **PART V. Execution.**

You must sign and date your Combined Mental Health Care Declaration and Power of Attorney in this section. If you are unable to sign for yourself, someone else may sign on your behalf. Your signature must be witnessed by two individuals at least 18 years of age. The witnesses may not be your agent, or a person signing on your behalf.

Be sure to give copies of this advance directive to your agent, mental health care provider, and anyone else that may be notified in the event that you are found not to have capacity to make mental health care decisions.

**Please Note: The information in this document is not intended to constitute legal advice applicable to specific factual situations. For specific advice contact the DLP/PP&A (Pennsylvania Protection & Advocacy) Intake line at 1-800-692-7443 (voice) or 1-877-375-7139 (TDD).**

## **Combined Mental Health Advance Directive Declaration and Power of Attorney Form**

### **Part I. Introduction.**

I, \_\_\_\_\_, having capacity to make mental health decisions, willfully and voluntarily make this declaration and power of attorney 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 Combined Mental Health Declaration and Power of Attorney becomes effective.**

This Combined Mental Health Declaration and Power of Attorney becomes effective at the following designated time:

\_\_\_ When I am deemed incapable of making mental health care decisions. I would prefer the following doctor(s) to evaluate me for my ability to make mental health decisions:

Name of Doctor: \_\_\_\_\_

Address/Phone Number: \_\_\_\_\_

\_\_\_ When the following condition is met: (List condition)

\_\_\_\_\_

## **B. Revocation and Amendments.**

This Combined Mental Health Care Declaration and Power of Attorney 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 power of attorney in the manner specified, I understand that the other instructions contained in this power of attorney will remain effective until:

- (1) I revoke this power of attorney in its entirety;
- (2) I make a new combined mental health care declaration and power of attorney; or
- (3) Two years from the date this document was executed.

I may make changes to this advance directive at any time, as long as I have capacity to make mental health care decisions. Any changes will be made in writing and be signed and witnessed by two individuals in the same way as the original document. Any changes will be effective as soon the changes are communicated to my attending physician or other mental health care provider, either by me, my agent, or a witness to my amendments.

## **C. 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 this declaration would expire.

## **Part II. Mental Health Declaration.**

### **A. 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:

Name of facility: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

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

Name of facility: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

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.

\_\_\_ I consent to the medications that my treating physician recommends with the following exceptions, limitations, and/or preferences:

Medication	Reason for Exception
_____	_____
_____	_____
_____	_____

I consent to the following medications with these limitations:

Medication	Limitation	Reason for Limitation
_____	_____	_____
_____	_____	_____
_____	_____	_____

I prefer the following medications:

Medication	Reason for Preference
_____	_____
_____	_____
_____	_____

The exception, limitation, or preference, applies to generic, brand name and trade name equivalents unless otherwise stated. I understand that dosage instructions are not binding on my physician.

I have designated an agent under the power of attorney portion of this document to make decisions related to medication.

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 have designated an agent under the power of attorney portion of this document to make decisions related to electroconvulsive therapy.

I do not consent to the administration of electroconvulsive therapy.

**4. Preferences for experimental studies.**

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 have designated an agent under the power of attorney portion of this document to make decisions related to experimental studies.

I do not consent to participation in experimental studies.

**5. Preferences for drug trials.**

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 have designated an agent under the power of attorney portion of this document to make decisions related to drug trials.

I do not consent to participation in any drug trials.

**6. Additional instructions or information.**

Examples of other instructions or information that may be included:

Activities that help or worsen symptoms:

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Type of intervention preferred in the event of a crisis:

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Mental and physical health history:

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Dietary requirements:

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Religious preferences:

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Temporary custody of children:

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Family notification:

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Limitations on the release or disclosure of mental health records:

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Temporary care and custody of pets:

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Other matters of importance:

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**Part III. Mental Health Care Power of Attorney**

I, \_\_\_\_\_, having the capacity to make mental health decisions, authorize my designated health care agent to make certain decisions on my behalf regarding my mental health

care. If I have not expressed a choice in this document or in the accompanying declaration, I authorize my agent to make the decision that my agent determines is the decision I would make if I were competent to do so.

**A. Designation of agent.**

I hereby designate and appoint the following person as my agent to make mental health care decisions for me as authorized in this document. This authorization applies only to mental health decisions that are not addressed in the accompanying signed declaration.

Name of designated person:

\_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Agent's acceptance:

I hereby accept designation as mental health care agent for (Insert name of declarant)  
\_\_\_\_\_ .

Agent's signature: \_\_\_\_\_

Name of Agent:

\_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code:  
\_\_\_\_\_

Phone Number:  
\_\_\_\_\_

**B. Designation of alternative agent.**

In the event that my first agent is unavailable or unable to serve as my mental health care agent, I hereby designate and appoint the following individual as my alternative mental health care agent to make mental health care decisions for me as authorized in this document:

Name of designated person:

\_\_\_\_\_

Address:

\_\_\_\_\_  
City, State, Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Alternative Agent's acceptance:

I hereby accept designation as alternative mental health care agent for (Insert name of declarant)  
\_\_\_\_\_ .

Alternate Agent's signature:  
\_\_\_\_\_

Name of Alternate Agent:  
\_\_\_\_\_

Address:  
\_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**C. Authority granted to my mental health care agent.**

I hereby grant to my agent full power and authority to make mental health care decisions for me consistent with the instructions and limitations set forth in this document. If I have not expressed a choice in this power of attorney, or in the accompanying declaration, I authorize my agent to make the decision that my agent determines is the decision I would make if I were competent to do so.

**(1) Preferences regarding medications for psychiatric treatment.**

My agent is authorized to consent to the use of any medications after consultation with my treating psychiatrist and any other persons my agent considers appropriate.

My agent is not authorized to consent to the use of any medications.

**(2) Preferences regarding electroconvulsive therapy (ECT).**

My agent is authorized to consent to the administration of electroconvulsive therapy.

My agent is not authorized to consent to the administration of electroconvulsive therapy.

**(3) Preferences for experimental studies.**

My agent is authorized to consent to my participation in experimental studies if, after consultation with my treating physician and any other individuals my agent deems appropriate, my agent believes that the potential benefits to me outweigh the possible risks to me.

My agent is not authorized to consent to my participation in experimental studies.

**(4) Preferences regarding drug trials.**

\_\_\_ My agent is authorized to consent to my participation in drug trials if, after consultation with my treating physician and any other individuals my agent deems appropriate, my agent believes that the potential benefits to me outweigh the possible risks to me.

\_\_\_ My agent is not authorized to consent to my participation in drug trials.

**PART IV. Nominating a Guardian.**

**A. 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 under 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:

Name of Person: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_

\_\_\_ The appointment of a guardian of my person will not give the guardian the power to revoke, suspend or terminate this Combined Mental Health Care Declaration and Power of Attorney

\_\_\_ Upon appointment of a guardian, I authorize the guardian to revoke, suspend or terminate this Combined Mental Health Care Declaration and Power of Attorney.

**PART V. Execution.**

I am making this Combined Mental Health Care Declaration and Power of Attorney on the

\_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.  
month year

My Signature: \_\_\_\_\_

My Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Witness Signature

Name of Witness: \_\_\_\_\_

Address:  
\_\_\_\_\_

City, State, Zip Code:  
\_\_\_\_\_

Phone Number: \_\_\_\_\_

Name of Witness: \_\_\_\_\_

Address:  
\_\_\_\_\_

City, State, Zip Code:  
\_\_\_\_\_

Phone Number: \_\_\_\_\_

If the principal making this Combined Mental Health Care Declaration and Power of Attorney is unable to sign this document, another individual may sign on behalf of and at the direction of the principal. An agent or a person signing on behalf of the principal may not also be a witness.

Signature of person signing on my behalf: \_\_\_\_\_

Name of Person:  
\_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code:  
\_\_\_\_\_

Phone Number:  
\_\_\_\_\_