Directions for using the Mental Health Advance Directive Declaration form.

1. Read each section very carefully.

2. 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 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. If you do not have a preference in a given section, you may leave it blank.

5. 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.

6. 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.

7. In order for your declaration 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:

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. Treatment Preferences.

You should note that your advance directive will be less likely to be challenged if you include information about what you do want, as well as what you don't want.

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 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.

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.

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.

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 doctor and people 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 doctor 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, just leave that particular section blank.

C. Revocation and Amendments.

Revocation means that you are canceling your declaration. If you revoke your declaration, your doctor will no longer have to follow the instructions that you gave in the

document. You may change or revoke your declaration at any time, as long as you have capacity to make mental health decisions when you make the change or revocation. You may revoke a specific instruction without revoking the entire document.

If you are currently under an involuntarily commitment, and you want to change or revoke your declaration, 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 declaration, even though you are in the hospital.

You may revoke your declaration orally or in writing. It becomes effective 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 declaration, you should be sure to notify your doctor and support people that you have revoked the old one. Your declaration 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 as the original document. 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, or a witness to your amendments.

D. Termination.

Your Declaration 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 declaration will continue to be in force until you regain capacity.

E. Preference as to a court-appointed guardian.

If you become ill, 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 declaration, 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 declaration 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 declaration 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.

F. Execution.

You must sign and date your Declaration 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. A person signing on your behalf may not be a witness.

Be sure to give copies of this advance directive to your 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 Disability Rights Network of Pennsylvania Intake line at 1-800-692-7443 (voice) or 1-877-375-7139 (TDD).

I,_____, having 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. 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. 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 exception, preference or limitation:

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 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.
___ 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.

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 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:
_____
_____
_____
_____

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:

_____
_____
_____
_____

Temporary care and custody of pets:

_____
_____
_____

Other matters of importance:

_____
_____
_____
_____

C. Revocation and Amendments.

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 advance diective; or
(3) Two years after 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 the original document was executed. Any changes will be effective as soon the changes are communicated to my attending physician or other mental health care provider, either by me or a witness to my amendments.

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 this 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 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 declaration.
___ Upon appointment of a guardian, I authorize the guardian to revoke, suspend or terminate this declaration.

F. Execution.

I am making this declaration 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 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 of Person: _____

Address: _____

City, State, Zip Code: _____

Phone Number: _____