If you are unable to make decisions for yourself because of an accident or illness, would those persons caring for you know how to treat you? Would your family and your doctors know how you would want decisions made about your care? A living will is a written instrument by which you can outline the kind of treatment you want for yourself at the end of your life. Generally a living will only takes effect when you are not able to speak for yourself.

A durable power of attorney for health care is a person you wish to have make health care decisions for you anytime you are not able to speak for yourself.

ADVANCE DIRECTIVES Are they for me?

Declaration for Mental Health Treatment

Because the symptoms of a mental disorder might make you unable to express your true wishes about mental health treatment, you can specify in advance your preference for mental health treatment in a Declaration for Mental Health Treatment. The Declaration allows you to name the specific symptoms for which you would want or not want mental health treatment. Treatments covered by the Declaration include psychotropic medication, electroconvulsive treatment (ECT) and admission to and retention in a mental health treatment facility. You can also appoint an individual to make decisions about your mental health treatment if you are unable to do so. Mental Health Centers of Central Illinois makes these forms available in a separate brochure available upon request. More information can be obtained by contacting your nurse or case manager.

The Illinois Healthcare Surrogate Act

When there is not Living Will or Durable Power of Attorney for Healthcare this law allows family members (and others) to make health care decisions on behalf of a patient who is not able to make decisions for himself. The Act outlines a formal order in which persons may serve as surrogate decision-makers. It also describes the particular circumstances that must exist for making different types of treatment decisions.

Additional Information

Date: ____________________________________
Name: ___________________________________

I have: ☐ Power of Attorney for Healthcare
☐ Living Will
☐ Mental Health Treatment Declaration

My Agent is: _______________________________
Phone: ___________________________________
Signed: ___________________________________

Cut along dotted line and keep in your wallet.

Power of Attorney for Health Care Pocket Card

The purpose of a power of attorney is to give the person you designate (your “agent”) the power to make health care decisions for you, including the power to require, consent to or withdraw any type of personal care or medical treatment for any physical or mental condition and to admit you to or discharge you from any hospital, nursing home or other institution. (755 ILCS 454)

I understand the above statement and designate _______________________________ as my agent. My agent’s phone number is _______________________________.

Cut along dotted line and keep in your wallet.
Living Will:

- A living will is a way of writing down which medical treatments you do or do not want at the end of your life.
- A living will takes effect only when you can no longer express your wishes yourself.
- A living will takes effect only if your physician(s) have determined that you suffer from a terminal or incurable, irreversible condition and death is imminent.
- A living will generally applies only to treatments that are considered "life-support" or "life-prolonging" such as the use of a ventilator.

Durable Power of Attorney for Healthcare:

- In addition to providing a way to record specific wishes you may have about medical treatments, this document allows you to name another person (proxy or agent) who can speak for you and make healthcare decisions for you if, and only if, you are unable to speak for yourself.
- The agent has the authority to act on your behalf anytime you are unable to speak for yourself, your condition does not have to be terminal or irreversible.
- The agent has the authority to speak for you and decide on your behalf regarding any healthcare decisions that might need to be made, not just decisions about life-support equipment but including things like consent to invasive procedures, surgery, and dialysis.
- You may give the agent specific instructions regarding certain issues or you may chose to limit his or her authority.

How do I know what I want?

Ask yourself what is most important to you in life. How important is it to you to be physically and/or financially independent? What physical and/or mental limitations could you accept and still find life meaningful and enjoyable? What fears, if any, do you have about injuries or illnesses that might significantly change your life?

Whether or not we belong to an organized religious community, we all have values, beliefs and life goals that guide our thinking about life and death. What do you believe about such issues and the role of suffering and pain (do they have any meaning?) or the prolonging of life when recovery is not possible? You might want to talk with family, close friends or clergy to help you clarify your beliefs about life and the end of life.
You might want to use the following chart to help identify some of your most important values related to health and healthcare: (Rate each item from 1 [very important] to 5 [not at all important])

<table>
<thead>
<tr>
<th>Item</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caring for myself without assistance</td>
<td>1</td>
</tr>
<tr>
<td>Being able to get out of bed (not bedfast)</td>
<td>1</td>
</tr>
<tr>
<td>Able to move about independently</td>
<td>1</td>
</tr>
<tr>
<td>Able to recognize other persons like family and friends</td>
<td>1</td>
</tr>
<tr>
<td>Able to verbally communicate with others</td>
<td>1</td>
</tr>
<tr>
<td>Able to make and express my own decisions</td>
<td>1</td>
</tr>
<tr>
<td>Able to live in my own home</td>
<td>1</td>
</tr>
<tr>
<td>Freedom from chronic, severe pain</td>
<td>1</td>
</tr>
<tr>
<td>Not being dependent on machines or invasive treatments to keep me alive</td>
<td>1</td>
</tr>
<tr>
<td>Financial independence</td>
<td>1</td>
</tr>
<tr>
<td>Leaving a substantial estate to people or causes important to me</td>
<td>1</td>
</tr>
<tr>
<td>Living, and dying, in keeping with my beliefs</td>
<td>1</td>
</tr>
<tr>
<td>Living as long as possible without regard to health</td>
<td>1</td>
</tr>
<tr>
<td>Receiving all possible medical treatment</td>
<td>1</td>
</tr>
<tr>
<td>Dying as naturally as possible</td>
<td>1</td>
</tr>
</tbody>
</table>

What are my choices?

Depending upon your medical condition, there may be many treatment decisions that can be made. Some treatments may extend the length of your life but may not improve its quality. Other treatments may have a low likelihood of success and involve a great deal of pain and discomfort, as well as cost. There may be treatments that you would agree to in one set of circumstances and not another. You should always feel free to ask your personal physician about the expected benefits as well as potential risks and burdens of proposed treatments.

- **Unexpected complication**: If treated promptly and aggressively, your chances of a full recovery are usually very good.
- **Chronic condition**: Diseases like emphysema or diabetes can be treated well for many years but eventually even the best care will not be able to control the disease or its symptoms.
- **Incurable diseases**: Some diseases, like advanced cancer and AIDS, can be treated for a time and your life extended but your condition will worsen over time and the disease will not be cured.
- **PVS (persistent vegetative state) or irreversible coma**: Brain damage in these situations is irreversible and treatment is highly unlikely to lead to your regaining consciousness. Ventilators and tube-feedings can keep your heart and lungs working for a long time but they cannot restore the functioning of your brain.

**LIVING WILL**

- **Medical Record Number____________**
- **Social Security Number____________**
- **Date___________________________**
- **Name___________________________**

I, ________________________________ wish to make known to those who may be charged with my care that I desire that my moment of death not be artificially postponed.

If I should have an incurable and irreversible injury, disease or illness that, in my attending physician’s judgment, will lead to my imminent death, I direct that any procedures or treatments that would only prolong my dying be withheld or withdrawn. I ask that I be provided only those treatments that will, in my physician’s judgment, contribute to my comfort.

In the event of my inability to personally give direction regarding my care, it is my intention that this statement be honored by my family and my physicians as my legal right to refuse medical or surgical treatment. I understand and accept the consequence of my refusal.

Additional Directives:

Additional Directives:

Signed____________________________________________________________________________

City, County, and State of residence: ______________________________________________________Date:____________________

The declarant is personally known to me and I believe him or her to be of sound mind. I saw the declarant sign the declaration in my presence (or the declarant acknowledged in my presence that he or she had signed the declaration) and I signed the declaration as a witness in the presence of the declarant. I did not sign the declarant’s signature above for or at the direction of the declarant. At the date of this instrument, I am not entitled to any portion of the estate of the declarant according to the laws of intestate succession or, to the best of my knowledge and belief, under any will of declarant or other instrument taking effect at declarant’s death, or directly financially responsible for declarant’s medical care.

Witness:____________________________________________________

Witness:_____________________________________________________
General preferences: You **may** choose to use one of the following statements to express your preferences. Please initial only one:

- **I do not want** my life to be prolonged when recovery is not possible. **I do not want** life-sustaining treatment to be provided or continued **if** my agent believes the burdens of the treatment outweigh the expected benefits to me. **I do want** my agent to consider the relief of suffering, the expense involved and the quality of my life in making decisions concerning life-sustaining treatment. **I do want** to receive those treatments which are intended only for my comfort and relief of suffering.

- **I do want** my life to be prolonged and I **do want** life-sustaining treatment to be provided or continued **unless** I am in a coma from which my attending physician believes I will not recover. If and when I have suffered irreversible coma, **I do want** life-sustaining treatment to be withheld or discontinued. **I do want** to receive those treatments which are intended only for my comfort and relief of suffering.

- **I do want** my life to be prolonged to the greatest extent possible without regard to my condition, the chances I have for recovery or the cost of the procedures.

Successor agents: If my agent named by me shall die or become unable or unwilling to serve, I name the following persons to act on my behalf in this order:

1. Name: _________________________________________________________________________________  
   Address: _________________________________________________________________________________  
   Phone: _________________________________________________________________________________

2. Name: _________________________________________________________________________________  
   Address: _________________________________________________________________________________  
   Phone: _________________________________________________________________________________

This power of attorney shall be effective on _________________ and shall continue until ________________.

I fully understand all the contents of this form and I understand the authority I am granting to my agent.  

(Principal)

The principal has read the above form (or had it read to them) and has signed it (or acknowledged their mark) in my presence.  

Witness: _________________________________________________________________________________  

Address: _________________________________________________________________________________

**This form may be witnessed by any adult (over the age of 18) who is not named as agent or successor agent. Direct healthcare providers may serve as WITNESSES, however, they may not be named as AGENT or SUCCESSOR AGENT.**

Sometimes we talk about treatment choices as **life-supporting**, by which we usually mean the use of a respirator (or ventilator) to mechanically breathe for you and/or the use of CPR (chest compressions) and drugs to try to restart your heart and lungs when they stop working; **life-sustaining** usually refers to treatments such as tube feeding when you are unable to chew or swallow or the use of a dialysis machine to clean your blood when your kidneys stop working; and **life-enhancing** treatments such as hospice care and aggressive use of pain medications so that your last days may be as comfortable as possible.

Outlining the exact treatment choices you would likely make or want made for you if you were unable to participate in decision-making can be very difficult. Generally people are most concerned about chronic and/or terminal conditions such as being on a ventilator for long periods of time, or even permanently; whether or not they are able to be aware of and interact with their surroundings; will they be kept comfortable and as pain-free as possible; and what is the likelihood that continued treatment will restore them to an acceptable quality of life? If there are potential situations that you can imagine and that you have strong feelings about, talk with your agent and your physician about your concerns.

What is an "Agent"?

Even the most knowledgeable and experienced healthcare worker would be unable to predict all the possible situations we might face in the future. So, even if you have a living will expressing your desires about the treatment you want, you may want to name someone you trust to make healthcare decisions for you when you are unable to do so yourself. A Durable Power of Attorney for Healthcare is a document which allows you to appoint an agent for yourself.

- Your agent’s responsibility is to see that your wishes for medical treatment are followed as closely as possible. If your specific wishes about a treatment are not known, it is the agent’s duty to use his or her knowledge of you, your wishes, beliefs and values, to decide as they believe you would decide.

- Your agent has the authority to make all healthcare related decisions including disposition of your body after death. A friend appointed as ‘agent’ can overrule family wishes.

- You can give your agent specific directions. You can also place specific limitations upon their authority.

- Your agent (under a DPOAH) has no control over or access to your financial resources and cannot be held responsible for your expenses.

State regulations vary. Most states will honor an advance directive which is legal in the state it was first written. However, if you move to another state, or spend significant time in another state (such as winters) you may want to check on the laws in that state to ensure that your wishes can still be carried out.

Who should I choose?

Serving as healthcare agent for another person is a serious responsibility. Take time to consider who can most effectively serve in this role for you.

- Your agent must be someone who is at least 18 years of age.

- Your agent should be someone who knows you well and to whom you feel comfortable communicating your wishes regarding health care.
I, ____________________________________, appoint____________________________________________ to serve as my attorney-in-fact (my 'agent') for healthcare whenever I am unable to participate in, or communicate, healthcare treatment decisions.

Agent's full name_______________________________________________
Agent's address________________________________________________Agent's work telephone________________________
Agent's home telephone__________________________
Agent's other telephone_________________________

• Except as limited hereafter, my agent may make any and all decisions for me concerning my personal care, medical treatment, hospitalization and healthcare in general.  This includes the authority to require, withhold or withdraw any type of medical treatment or procedure, even though my death may ensue, including the withdrawal of food and water.

• My agent shall have the same access to my medical records that I have, including the right to share the information with others as he or she feels necessary.

• My agent shall also have full power to authorize an autopsy and direct the disposition of my remains.

Effective upon my death, my agent has the full power to make an anatomical gift of the following (initial one):

• I direct my agent to make all decisions in keeping with his or her knowledge of my values and specific directions I may provide.

Special Conditions and Limitations: My agent's authority is limited by the following:
(You may limit the authority of your agent if you wish or you may choose to give specific instructions about issues you feel strongly about such as when to discontinue or withhold life-sustaining treatments; when to continue or withhold such treatments as nutrition and hydration, antibiotics, dialysis, or other treatments that are unacceptable to you because of religious beliefs or other reasons, such as blood transfusions, electroconvulsive therapy, psycho-surgery, voluntary admission to a mental institution, amputation, organ transplantation, etc.)

Conditions and Limitations: ________________________________

What do I do now?

• Complete the attached form(s), or use another form if you wish.  If you add additional pages make sure you sign and date them.

• Sign and date the form.  Any adult may witness the form.

• Make copies of the completed document and give them to your agent (and alternates, if any), your doctor(s), your family and any close friends who might be involved in your care.  If you can, carry a copy with you.  Make sure that a copy goes with you any time you might be hospitalized.

• If you make any later changes make sure everyone is aware of the changes.  You can create a new document if you wish and simply dispose of any old copies.

Anything else?

• Even though you have completed an Advance Directive, be sure you talk with your family and that they understand your wishes.

• Talk with your physician(s).  The more they understand your wishes and concerns, the better equipped they will be to treat you as you wish.
I, ____________________________________, appoint____________________________________________ to serve as my attorney-in-fact (my ‘agent’) for healthcare whenever I am unable to participate in, or communicate, healthcare treatment decisions.

Agent’s full name_______________________________________________
Agent’s address________________________________________________
Agent’s work telephone________________________
Agent’s home telephone__________________________
Agent’s other telephone_________________________

• Except as limited hereafter, my agent may make any and all decisions for me concerning my personal care, medical treatment, hospitalization and healthcare in general. This includes the authority to require, withhold or withdraw any type of medical treatment or procedure, even though my death may ensue, including the withdrawal of food and water.
• My agent shall have the same access to my medical records that I have, including the right to share the information with others as he or she feels necessary.
• My agent shall also have full power to authorize an autopsy and direct the disposition of my remains.
• I direct my agent to make all decisions in keeping with his or her knowledge of my values and specific directions I may provide.

Special Conditions and Limitations: My agent’s authority is limited by the following:
(You may limit the authority of your agent if you wish or you may choose to give specific instructions about issues you feel strongly about such as when to discontinue or withhold such treatments as nutrition and hydration, antibiotics, dialysis, or other treatments that are unacceptable to you because of religious beliefs or other reasons, such as blood transfusions, electroconvulsive therapy, psycho-surgery, voluntary admission to a mental institution, amputation, organ transplantation, etc.)

What do I do now?
• Complete the attached form(s), or use another form if you wish. If you add additional pages make sure you sign and date them.
• Sign and date the form. Any adult may witness the form.
• Make copies of the completed document and give them to your agent (and alternates, if any), your doctor(s), your family and any close friends who might be involved in your care. If you can, carry a copy with you. Make sure that a copy goes with you any time you might be hospitalized.
• If you make any later changes make sure everyone is aware of the changes. You can create a new document if you wish and simply dispose of any old copies.

Anything else?
• Even though you have completed an Advance Directive, be sure you talk with your family and that they understand your wishes.
• Talk with your physician(s). The more they understand your wishes and concerns, the better equipped they will be to treat you as you wish.

Medical Record Number________________________
Social Security Number________________________
Date_______________________________________
Name______________________________________

I, ____________________________________, appoint____________________________________________ to serve as my attorney-in-fact (my ‘agent’) for healthcare whenever I am unable to participate in, or communicate, healthcare treatment decisions.

Agent’s full name_______________________________________________
Agent’s address________________________________________________
Agent’s work telephone________________________
Agent’s home telephone__________________________
Agent’s other telephone_________________________

- Except as limited hereafter, my agent may make any and all decisions for me concerning my personal care, medical treatment, hospitalization and healthcare in general. This includes the authority to require, withhold or withdraw any type of medical treatment or procedure, even though my death may ensue, including the withdrawal of food and water.
- My agent shall have the same access to my medical records that I have, including the right to share the information with others as he or she feels necessary.
- My agent shall also have full power to authorize an autopsy and direct the disposition of my remains.
- Effective upon my death, my agent has the full power to make an anatomical gift of the following (initial one):
  - Any organ
  - Specific organs:___________________________________________________________________
- I direct my agent to make all decisions in keeping with his or her knowledge of my values and specific directions I may provide.

Special Conditions and Limitations: My agent’s authority is limited by the following:
(You may limit the authority of your agent if you wish or you may choose to give specific instructions about issues you feel strongly about such as when to discontinue or withhold life-sustaining treatments; when to continue or withhold such treatments as nutrition and hydration, antibiotics, dialysis, or other treatments that are unacceptable to you because of religious beliefs or other reasons, such as blood transfusions, electroconvulsive therapy, psycho-surgery, voluntary admission to a mental institution, amputation, organ transplantation, etc.)

Conditions and Limitations: __________________________________________________________________
General preferences: You may choose to use one of the following statements to express your preferences. Please initial only one:

_____ I do not want my life to be prolonged when recovery is not possible. I do not want life-sustaining treatment to be provided or continued if my agent believes the burdens of the treatment outweigh the expected benefits to me. I do want my agent to consider the relief of suffering, the expense involved and the quality of my life in making decisions concerning life-sustaining treatment. I do want to receive those treatments which are intended only for my comfort and relief of suffering.

_____ I do want my life to be prolonged and I do want life-sustaining treatment to be provided or continued unless I am in a coma from which my attending physician believes I will not recover. If and when I have suffered irreversible coma, I do want life-sustaining treatment to be withheld or discontinued. I do want to receive those treatments which are intended only for my comfort and relief of suffering.

_____ I do want my life to be prolonged to the greatest extent possible without regard to my condition, the chances I have for recovery or the cost of the procedures.

Successor agents: If my agent named by me shall die or become unable or unwilling to serve, I name the following persons to act on my behalf in this order:

1. Name: _________________________________________________________________________________ Address: _________________________________________________________________________________ Phone: _________________________________________________________________________________

2. Name: _________________________________________________________________________________ Address: _________________________________________________________________________________ Phone: _________________________________________________________________________________

This power of attorney shall be effective on _________________ and shall continue until ________________.

I fully understand all the contents of this form and I understand the authority I am granting to my agent.

(Principal)

The principal has read the above form (or had it read to them) and has signed it (or acknowledged their mark) in my presence.

Witness: _________________________________________________________________________________ Address: _________________________________________________________________________________

**This form may be witnessed by any adult (over the age of 18) who is not named as agent or successor agent. Direct healthcare providers may serve as WITNESSES, however, they may not be named as AGENT or SUCCESSOR AGENT.**
You might want to use the following chart to help identify some of your most important values related to health and healthcare: (Rate each item from 1 [very important] to 5 [not at all important])

- Caring for myself without assistance 1 2 3 4 5
- Being able to get out of bed (not bedfast) 1 2 3 4 5
- Able to move about independently 1 2 3 4 5
- Able to recognize other persons like family and friends 1 2 3 4 5
- Able to verbally communicate with others 1 2 3 4 5
- Able to make and express my own decisions 1 2 3 4 5
- Able to live in my own home 1 2 3 4 5
- Freedom from chronic, severe pain 1 2 3 4 5
- Not being dependent on machines or invasive treatments to keep me alive 1 2 3 4 5
- Financial independence 1 2 3 4 5
- Leaving a substantial estate to people or causes important to me 1 2 3 4 5
- Living, and dying, in keeping with my beliefs 1 2 3 4 5
- Living as long as possible without regard to health 1 2 3 4 5
- Receiving all possible medical treatment 1 2 3 4 5
- Dying as naturally as possible 1 2 3 4 5

What are my choices?

Depending upon your medical condition, there may be many treatment decisions that can be made. Some treatments may extend the length of your life but may not improve its quality. Other treatments may have a low likelihood of success and involve a great deal of pain and discomfort, as well as cost. There may be treatments that you would agree to in one set of circumstances and not another. You should always feel free to ask your personal physician about the expected benefits as well as potential risks and burdens of proposed treatments.

- **Unexpected complication:** If treated promptly and aggressively, your chances of a full recovery are usually very good.
- **Chronic condition:** Diseases like emphysema or diabetes can be treated well for many years but eventually even the best care will not be able to control the disease or its symptoms.
- **Incurable diseases:** Some diseases, like advanced cancer and AIDS, can be treated for a time and your life extended but your condition will worsen over time and the disease will not be cured.
- **PVS (persistent vegetative state) or irreversible coma:** Brain damage in these situations is irreversible and treatment is highly unlikely to lead to your regaining consciousness. Ventilators and tube-feedings can keep your heart and lungs working for a long time but they cannot restore the functioning of your brain.

### LIVING WILL

<table>
<thead>
<tr>
<th>Medical Record Number</th>
<th>Social Security Number</th>
<th>Date</th>
<th>Name</th>
</tr>
</thead>
</table>

I, __________________________, wish to make known to those who may be charged with my care that I desire that my moment of death not be artificially postponed.

If I should have an incurable and irreversible injury, disease or illness that, in my attending physician’s judgment, will lead to my imminent death, I direct that any procedures or treatments that would only prolong my dying be withheld or withdrawn. I ask that I be provided only those treatments that will, in my physician’s judgment, contribute to my comfort.

In the event of my inability to personally give direction regarding my care, it is my intention that this statement be honored by my family and my physicians as my legal right to refuse medical or surgical treatment. I understand and accept the consequence of my refusal.

### Additional Directives:

Signed: __________________________

City, County, and State of residence: __________________________

Date: __________________________

The declarant is personally known to me and I believe him or her to be of sound mind. I saw the declarant sign the declaration in my presence (or the declarant acknowledged in my presence that he or she had signed the declaration) and I signed the declaration as a witness in the presence of the declarant. I did not sign the declarant’s signature above for or at the direction of the declarant. At the date of this instrument, I am not entitled to any portion of the estate of the declarant according to the laws of intestate succession or, to the best of my knowledge and belief, under any will of declarant or other instrument taking effect at declarant’s death, or directly financially responsible for declarant’s medical care.

Witness: __________________________

Witness: __________________________
Living Will:

- A living will is a way of writing down which medical treatments you do or do not want at the end of your life.
- A living will takes effect only when you can no longer express your wishes yourself.
- A living will takes effect only if your physician(s) have determined that you suffer from a terminal or incurable, irreversible condition and death is imminent.
- A living will generally applies only to treatments that are considered “life-support” or “life-prolonging” such as the use of a ventilator.

Durable Power of Attorney for Healthcare:

- In addition to providing a way to record specific wishes you may have about medical treatments, this document allows you to name another person (proxy or agent) who can speak for you and make healthcare decisions for you if, and only if, you are unable to speak for yourself.
- The agent has the authority to act on your behalf anytime you are unable to speak for yourself, your condition does not have to be terminal or irreversible.
- The agent has the authority to speak for you and decide on your behalf regarding any healthcare decisions that might need to be made, not just decisions about life-support equipment but including things like consent to invasive procedures, surgery, and dialysis.
- You may give the agent specific instructions regarding certain issues or you may chose to limit his or her authority.

How do I know what I want?

Ask yourself what is most important to you in life. How important is it to you to be physically and/or financially independent? What physical and/or mental limitations could you accept and still find life meaningful and enjoyable? What fears, if any, do you have about injuries or illnesses that might significantly change your life?

Whether or not we belong to an organized religious community, we all have values, beliefs and life goals that guide our thinking about life and death. What do you believe about such issues and the role of suffering and pain (do they have any meaning?) or the prolonging of life when recovery is not possible? You might want to talk with family, close friends or clergy to help you clarify your beliefs about life and the end of life.
ADVANCE DIRECTIVES
Are they for me?

If you are unable to make decisions for yourself because of an accident or illness, would those persons caring for you know how to treat you? Would your family and your doctors know how you would want decisions made about your care? A living will is a written instrument by which you can outline the kind of treatment you want for yourself at the end of your life. Generally a living will only takes effect when you are terminally ill. A document which names a person you wish to have make health care decisions for you anytime you are not able to speak for yourself is known as a durable power of attorney for health care.

DECLARATION FOR MENTAL HEALTH TREATMENT

Because the symptoms of a mental disorder might make you unable to express your true wishes about mental health treatment, you can specify in advance your preference for mental health treatment in a Declaration for Mental Health Treatment. The Declaration allows you to name the specific symptoms for which you would want or not want mental health treatment. The Act outlines a formal order in which persons may serve as surrogate decision-makers. It also describes the particular circumstances that must exist for making different types of treatment decisions.

THE ILLINOIS HEALTHCARE SURROGATE ACT

When there is not a Living Will or Durable Power of Attorney for Healthcare this law allows family members (and others) to make health care decisions on behalf of a patient who is not able to make decisions for himself. The Act outlines a formal order in which persons may serve as surrogate decision-makers. More information can be obtained by contacting the nearest hospital or case manager.

Additional Information

Power of Attorney for Health Care Pocket Card

The purpose of a power of attorney is to give the person you designate (your "agent") the power to make health care decisions for you, including the power to require, consent to or withdraw any type of personal care or medical treatment for any physical or mental condition and to admit you to an institution. (755 ILCS 454)

I understand the above statement and designate________________________as my agent.

Cut along dotted line and keep in your wallet.

Date: ________________________
Name: ________________________

I have: ☐ Power of Attorney for Healthcare
☐ Living Will
☐ Mental Health Treatment Declaration

My Agent is: ________________________
Phone: ________________________
Signed: ________________________
ADVANCE DIRECTIVES

Are they for me?

Date: ____________________________
Print your name: _____________________________________
Signature: ________________________________________
Witnessed by: (Signature and Address) ___________________
__________________________________________________________________________________________________________________________________________
My Advance Directive is on file in: _________________________________________________________________

(217) 525-1064
710 North Eighth Street
Springfield, Illinois 62702

www.mhcci.org