ADVANCE DIRECTIVES

Mental Health Treatment Declaration

Date: ___________________________
Print Name: _______________________
Signature: _________________________
Acceptance Attorney-In-Fact Signature:
Witnessed by two individuals:

My Mental Health Declaration is on file in: ____________________________________

Form 351 7/2009 184-0117
Advance Directives is a general term used to describe different ways of documenting your healthcare wishes. In Illinois, the four primary forms of Advance Directives forms are: a Living Will, a Mental Health Treatment Declaration, the Illinois Department of Public Health (IDPH) do not resuscitate (DNR) Advance Directive and a Power of Attorney for Healthcare. It is important to understand the purpose of each form – this booklet is designed to explain the forms and their differences. You may fill out any or all of these forms depending on your personal goals. This booklet discusses the Mental Health Treatment Declaration (MHTD).

The Mental Health Treatment Declaration

The Illinois Mental Health Treatment Declaration enables an adult of sound mind to declare in advance preferences or instructions for mental health treatment should he/she become unable to make decisions, and to identify someone as an alternate decision maker (called an “attorney-in-fact”) during this period.

What is the Declaration?

The Mental Health Treatment Declaration, which is included in this booklet, allows you to accept or refuse mental health treatment based upon your wishes while competent, and to name an individual to speak for you (the “Attorney-In-Fact”). The preferences expressed in the Declaration take precedence over preferences expressed while incapacitated due to the symptoms of a mental disorder. This allows you to specify in advance, for example, that you wish to receive mental health treatment, even if you would refuse such treatment while suffering from a mental disorder; or, to refuse mental health treatment even if you would accept treatment while suffering from a mental disorder. For this reason, the Mental Health Treatment Declaration can only be revoked in writing, and only when you have been determined by a physician to be capable of making healthcare treatment decisions.

What treatments are covered?

You can make decisions in advance about three types of mental health treatment: electroconvulsive treatment (ECT); psychotropic medication; and admission to and retention in a mental health treatment facility.

The Mental Health Treatment Declaration is good for three years.

Who can fill out a Declaration?

A Declaration can only be filled out by an adult (18 years old or older), and can only be filled out when the person is of sound mind, as confirmed by two witnesses.

When does the Declaration take effect?

The Declaration only becomes effective after two physicians have determined that you are unable to make decisions on your own behalf.

Cut along dotted line and keep in your wallet:

Mental Health Treatment Declaration Pocket Card

The "Mental Health Treatment Declaration" allows you to accept or refuse mental health treatment based upon your wishes while competent, and to name an individual to speak for you (the "attorney-in-fact").

Psychotropic Medications: □ Yes □ No
Electroconvulsive Treatment: □ Yes □ No
Admission/Retention Healthcare Facility: □ Yes □ No

I hereby appoint as my Attorney-In-Fact: _______________________________________
My Attorney-In-Fact’s phone number is: _______________________________________

Date: ____________________________________
Name: ___________________________________

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

My Agent is: _______________________________
Phone: ___________________________________
Signed: ___________________________________
DECLARATION FOR MENTAL HEALTH TREATMENT

I, ______________________________________, being an adult of sound mind, willfully and voluntarily make this declaration for mental health treatment to be followed if it is determined by two physicians or the court that my ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that I lack the capacity to refuse or consent to mental health treatment. “Mental health treatment” means electroconvulsive treatment, treatment of mental illness with psychotropic medication and admission to and retention in a healthcare facility for a period up to 17 days.

I understand that I may become incapable of giving or withholding informed consent for mental health treatment due to the symptoms of a diagnosed mental disorder. These symptoms may include:

Psychotropic Medications
If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding psychotropic medications are as follows:

______ I consent to the administration of the following medications: _____________________________

______ I consent to the administration of those medications recommended by my physicians, and reviewed and approved by my Power of Attorney under this document. This consent is limited to those medications I explicitly “do not consent to” in the section below:

Conditions or limitations: _____________________________________________________________

Electroconvulsive Treatment
If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding electroconvulsive treatment are as follows:

______ I consent to the administration of electroconvulsive treatment.

______ I do not consent to the administration of electroconvulsive treatment.

Conditions or limitations: _____________________________________________________________

Admission to and Retention in a Healthcare Facility
If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding admission to and retention in a healthcare facility for mental health treatment are as follows:

______ I consent to being admitted to a healthcare facility for mental health treatment.

______ I do not consent to being admitted to a healthcare facility for mental health treatment.

This directive cannot, by law, provide consent to retain me in a facility for more than 17 days.

Conditions or limitations: _____________________________________________________________

Selection of Physician (Optional)
If it becomes necessary to determine if I have become incapable of giving or withholding informed consent for mental health treatment, I choose Dr. ____________________________ of ____________________________ to be one of the two physicians who will determine whether I am incapable. If that physician is unavailable, that physician’s designee shall determine whether I am incapable.
NOTICE TO PERSON MAKING A DECLARATION FOR MENTAL HEALTH TREATMENT

This is an important legal document. It creates a declaration for mental health treatment. Before signing this document, you should know these important facts:

This document allows you to make decisions in advance about three types of mental health treatment: psychotropic medication; electroconvulsive therapy; and short-term (up to 17 days) admission to a treatment facility. The instructions that you include in this declaration will be followed only if two physicians or the court believes that you are incapable of making treatment decisions. Otherwise, you will be considered capable to give or withhold consent for the treatments.

You may also appoint a person as your Attorney-In-Fact to make these treatment decisions for you if you become incapable. The person you appoint has a duty to act consistent with your desires as stated in this document. You can appoint another person by signing a form similar to the following:

**Revocation**

I, ____________________, willfully and voluntarily revoke my declaration for mental health treatment as indicated [ ] I revoke my entire declaration [ ] I revoke the following portion of my declaration

Date___________________    Signed_________________________________________

Signature of Principal

**Affirmation of Witnesses**

We affirm that the principal is personally known to us, that the principal signed or acknowledged the principal’s signature on this declaration for mental health treatment in our presence, that the principal appears to be of sound mind and not under duress, fraud or undue influence, that neither of us is:

• A person appointed as an Attorney-In-Fact by this document
• The principal’s attending physician or mental health service provider or a relative of the physician or provider
• The owner, operator, or relative of an owner or operator of a facility in which the principal is a patient or resident
• A person related to the principal by blood, marriage or adoption.

Witnessed by:

Signature of Witness/Date     Printed Name of Witness

Signature of Witness/Date     Printed Name of Witness

**Acceptance of appointment as Attorney-In-Fact**

I accept this appointment and agree to serve as Attorney-In-Fact to make decisions about mental health treatment for the principal. I understand that I have a duty to act consistent with the desires of the principal as expressed in this appointment. I understand that this document gives me authority to make decisions about mental health treatment only while the principal is incapable as determined by a court or two physicians. I understand that the principal may revoke this declaration in whole or in part at any time and in any manner when the principal is not incapable.

Signature of Attorney-In-Fact/Date   Printed Name

Signature of Alternate Attorney-In-Fact/Date   Printed Name

**Conditions or limitations:**

Attorney-In-Fact

I hereby appoint:

Name________________________________________  Address_______________________________________   Telephone_____________________

Telephone

to act as my Attorney-In-Fact to make decisions regarding my mental health treatment if I become incapable of giving or withholding informed consent for that treatment. If the person named above refuses or is unable to act on my behalf, or if I revoke that person’s authority to act as my Attorney-In-Fact, I authorize the following person to act as my Attorney-In-Fact:

Name________________________________________  Address_______________________________________   Telephone_____________________

My Attorney-In-Fact is authorized to make decisions that are consistent with the wishes I have expressed in this declaration or, if not expressed, as are otherwise known to my Attorney-In-Fact. If my wishes are not expressed and are not otherwise known by my Attorney-In-Fact, my Attorney-In-Fact is to act in what he or she believes to be my best interest.

Signature of Principal    Date

**Additional References or Instructions**

If there is anything in this document that you do not understand, you should ask an attorney. This declaration will not be valid unless it is signed by two qualified witnesses who are personally known to you and who are present when you sign or acknowledge your signature.
NOTICE TO PERSON MAKING A DECLARATION FOR MENTAL HEALTH TREATMENT

This is an important legal document. It creates a declaration for mental health treatment. Before signing this document, you should know these important facts:

This document allows you to make decisions in advance about three types of mental health treatment: psychotropic medication; electroconvulsive therapy; and short-term (up to 17 days) admission to a treatment facility. The instructions that you include in this declaration will be followed only if two physicians or the court believes that you are incapable of making treatment decisions. Otherwise, you will be considered capable to give or withhold consent for the treatments.

You may also appoint a person as your Attorney-In-Fact to make these treatment decisions for you if you become incapable. The person you appoint has a duty to act consistent with your desires as stated in this document. The other person has the right to withdraw from acting as your Attorney-In-Fact at any time.

This document will continue in effect for a period of three years unless you become incapable of participating in mental health treatment decisions. If this occurs, the directive will continue in effect until you are no longer incapable.

You have the right to revoke this document in whole or in part at any time you have been determined by a physician to be capable of giving or withholding informed consent for mental health treatment. A revocation is effective on notice in writing and is signed by you and a physician. The revocation may be in a form similar to the following:

Revocation
I, ___________________________, willfully and voluntarily revoke my declaration for mental health treatment as indicated
[ ] I revoke my entire declaration
[ ] I revoke the following portion of my declaration

Date ___________________________    Signed _______________________________________
Signature of Principal

I, Dr. __________________________, have evaluated the principal and determined that he or she is capable of giving or withholding informed consent for mental health treatment.

Date ___________________________    Signed _______________________________________
Signature of Physician

Additional References or Instructions

Conditions or limitations:

Attorney-In-Fact
I hereby appoint:
Name ___________________________ Address ___________________________
Telephone ___________________________

My Attorney-In-Fact is authorized to make decisions that are consistent with the wishes I have expressed in this declaration or, if not expressed, as are otherwise known to my Attorney-In-Fact. If my wishes are not expressed and are not otherwise known by my Attorney-In-Fact, my Attorney-In-Fact is to act in what he or she believes to be my best interest.

Signature of Principal ___________________________
Date ___________________________

Affirmation of Witnesses

We affirm that the principal is personally known to us, that the principal signed or acknowledged the principal’s signature on this declaration for mental health treatment in our presence, that the principal appears to be of sound mind and not under duress, fraud or undue influence, that neither of us is:

• A person appointed as an Attorney-In-Fact by this document
• The principal’s attending physician or mental health service provider or a relative of the physician or provider
• The owner, operator, or relative of an owner or operator of a facility in which the principal is a patient or resident
• A person related to the principal by blood, marriage or adoption.

Witnessed by:

Signature of Witness/Date ___________________________
Printed Name of Witness ___________________________

Signature of Witness/Date ___________________________
Printed Name of Witness ___________________________

Acceptance of appointment as Attorney-In-Fact
I accept this appointment and agree to serve as Attorney-In-Fact to make decisions about mental health treatment for the principal. I understand that I have a duty to act consistent with the desires of the principal as expressed in this appointment. I understand that this document gives me authority to make decisions about mental health treatment only while the principal is incapable as determined by a court or two physicians. I understand that the principal may revoke this declaration in whole or in part at any time and in any manner when the principal is not incapable.

Signature of Attorney-In-Fact ___________________________
Date ___________________________
Printed Name ___________________________

Signature of Alternate Attorney-In-Fact ___________________________
Date ___________________________
Printed Name ___________________________

If there is anything in this document that you do not understand, you should ask an attorney. This declaration will not be valid unless it is signed by two qualified witnesses who are personally known to you and who are present when you sign or acknowledge your signature.
DECLARATION FOR MENTAL HEALTH TREATMENT

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Conditions or limitations: ________________________________________________________

Electroconvulsive Treatment
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- I do not consent to the administration of electroconvulsive treatment.

Conditions or limitations: ________________________________________________________

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Conditions or limitations: ________________________________________________________

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If it becomes necessary to determine if I have become incapable of giving or withholding informed consent for mental health treatment, I choose Dr. ___________________________ of ___________________________ to be one of the two physicians who will determine whether I am incapable. If that physician is unavailable, that physician’s designee shall determine whether I am incapable.
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Psychotropic Medications: ☻ Yes ☻ No
Electroconvulsive Treatment: ☻ Yes ☻ No
Admission/Retention Healthcare Facility: ☻ Yes ☻ No
I hereby appoint as my Attorney-In-Fact: _______________________________
My Attorney-In-Fact's phone number is: ________________________________________

Date: ____________________________________
Name: ___________________________________
I have: ☻ Power of Attorney for Healthcare
☻ Living Will
☻ Mental Health Treatment Declaration
My Agent is: _______________________________
Phone: _________________________________
Signed:___________________________________

Power of Attorney for Healthcare
Living Will
Mental Health Treatment Declaration
ADVANCE DIRECTIVES

Mental Health Treatment Declaration

Date: _______________________
Print Name: ______________________
Signature: ______________________
Acceptance Attorney-In-Fact Signature: ______________________
Witnessed by two individuals: ______________________

My Mental Health Declaration is on file in: ______________________

Form 351 7/2009 184-0117

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