Declaration For Mental Health Treatment

I,_____, being an adult of sound mind, wilfully and voluntarily make this declaration for mental health treatment to be followed if it is determined by a court that my ability to understand the nature and consequences of a proposed treatment, including the benefits, risks, and alternatives to the proposed treatment, is impaired to such an extent that I lack the capacity to make mental health treatment decisions. "Mental health treatment", means electroconvulsive or other convulsive treatment, treatment of mental illness with psychoactive medication, and preferences regarding emergency mental health treatment. (Optional Paragraph) 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:

_____

Psychoactive Medications

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

_____I consent to the administration of the following medications:

_____

_____I do not consent to the administration of the following medications:

_____

_____I consent to the administration of a federal Food and Drug Administration approved medication that was only approved and in existence after my declaration and that is considered in the same class of psychoactive medications as stated below:

_____

_____

Conditions or limitations: _____

_____

_____

Convulsive Treatment

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

_____I consent to the administration of convulsive treatment.

_____I do not consent to the administration of convulsive treatment.

Conditions or limitations: _____

_____

_____

Preferences For Emergency Treatment

In an emergency, I prefer the following treatment FIRST (circle one)
Restraint Seclusion Medication.
In an emergency, I prefer the following treatment SECOND (circle one)
Restraint Seclusion Medication.
In an emergency, I prefer the following treatment THIRD (circle one)
Restraint Seclusion Medication.

_____I prefer a male/female to administer restraint, seclusion, and/or medications.

Options for treatment prior to use of restraint, seclusion, and or medications:

_____

Conditions or limitations:_____

_____

Additional Preferences or Instructions:

_____

_____

Conditions or limitations:

_____

_____

Signature of Principal/Date: _____