Declaration for Mental Health Treatment

Distributed by the
Mental Health Association of Portland
www.mentalhealthportland.org
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I, _____, being an adult of sound mind, willfully and voluntarily make this declaration for mental health treatment. I want this declaration to be followed if a court or two physicians determine that I am unable to make decisions for myself because 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 treatment of mental illness with psychoactive medications, admission to and retention in a healthcare facility for a period of up to 17 days, convulsive treatment, and outpatient services that are specified in this declaration.

Choice of Decision Maker

If I become incapable of giving or withholding informed consent for mental health treatment, I want these decisions to be made by: (INITIAL ONLY ONE)

____ My appointed representative consistent with my desires, or, if my desires are unknown by my representative, consistent with what my representative believes to be my best interests.

____ The mental health treatment provider who requires my consent in order to treat me, but only as specifically authorized in this declaration.

Appointed Representative

If I have chosen to appoint a representative to make mental health treatment decisions for me when I am incapable, I am naming that person here. I may also name an alternative representative to serve. Each person I appoint must accept my appointment in order to serve. I understand that I am not required to appoint a representative in order to complete this declaration.

I hereby appoint: NAME _____

ADDRESS _____

_____

TELEPHONE _____

To act as my representative to make decisions regarding my mental health treatment if a court or two physicians determine that I am incapable of giving or withholding informed consent for that treatment.

(OPTIONAL) 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 representative, I authorize the following person to act as my representative:

NAME _____

ADDRESS _____

_____

TELEPHONE _____

My representative is authorized to make decisions that are consistent with the wishes I have expressed in this declaration or, if not expressed, and are not otherwise known by my representative, my representative is to act in what he or she believes is my best interests. My representative is also authorized to receive information regarding my proposed mental health treatment and to receive, review and consent to disclosure of medical records relating to that treatment.

Directions for Mental Health Treatment

This declaration permits me to state my wishes regarding mental health treatments including psychoactive medications, admission to and retention in a health care facility for mental health treatment for a period not to exceed 17 days, convulsive treatment, and outpatient services.

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes are the following:

I CONSENT TO THE FOLLOWING MENTAL HEALTH TREATMENTS: (CIRCLE ONE - "C" if you consent, "NC" if you do not consent)

C / NC The following psychoactive medications which I take currently, or have received before:

_____ _____

_____ _____

_____ _____

C / NC Psychoactive medications not listed above, if my attending physicians believe they are in my best interest.

C / NC Convulsive treatment, including electroconvulsive therapy (ECT)

C / NC Hospitalization in a locked health care facility for a limited duration, not to exceed 17 days.

I DO NOT CONSENT TO THE FOLLOWING MENTAL HEALTH TREATMENTS: (CIRCLE ONE - "C" if you consent, "NC" if you do not consent)

C / NC Treatment with the following medications, to which I am allergic:

_____ _____

_____ _____

_____ _____

C / NC Treatment with the following medications, due to prior adverse reactions:

_____ _____

_____ _____

_____ _____

(INITIAL) _____ I am aware I may be treated without consent if I am held pursuant to civil commitment law.

Additional Information

My most recent mental health diagnosis: _____

Contact information for the doctor who made this diagnosis:

NAME _____ Date of diagnosis _____

ADDRESS _____ Telephone _____

Contact information for my current treating physician (if different from above):

NAME _____

ADDRESS _____ Telephone _____

Contact information for other provider:

NAME _____

ADDRESS _____ Telephone _____

While hospitalized, I prefer the following health care providers:

_____ _____

_____ _____

_____ _____

While hospitalized, I prefer not to receive care from the following health care providers:

_____ _____

_____ _____

_____ _____

I wish to receive the following alternative treatments:

_____

_____

_____

_____

Further information about my **mental health care** I want any medical provider treating me to know:

_____

_____

_____

_____

Information about my **physical care** I want any medical provider treating me to know:

_____

_____

_____

_____

Information about my **dietary requirements** I want any health care facility holding me to know:

_____

_____

_____

_____

Information about my **religious concerns** I want any health care facility holding me to know:

_____

_____

_____

_____

Persons I want notified if I am to be held for more than 48 hours:

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

My signature below makes this declaration effective.

Name _____ Date _____

Affirmation of Witnesses

I affirm that the person signing this declaration:

1. Is a person known to me;
2. Signed or acknowledged his or her signature on this declaration in my presence;
3. Appears to be of sound mind and not under duress, fraud or undue influence;
4. Is not related to me by blood, marriage or adoption;
5. Is not a patient, client or resident in a facility that I or my relative owns or operates;
6. Is not my patient, client or resident in a facility where I am employed;
7. Does not receive mental health services from me or my relative;
8. Has not appointed me as a representative in this document.

Witnessed by:

_____	_____	_____
Signature of WITNESS	Printed name of WITNESS	Date
_____	_____	_____
Signature of WITNESS	Printed name of WITNESS	Date

Acceptance of Appointment as Representative

I accept this appointment and agree to serve as representative to make mental health treatment decisions. I understand that I must act consistently with the desires of the person I represent, as expressed in this declaration or, if not expressed, as otherwise known by me. If I do not know the desires of the person I represent, I have a duty to act in what I believe in good faith to be that person's best interest. I understand that this document gives me the authority to make decisions about mental health treatment only while that person has been determined to be incapable of making those decisions by a court or two physicians. I understand that the person who appointed me may revoke this declaration in whole or in part by communicating the revocation to the attending physician or other provider when the person is not incapable.

_____	_____	_____
Signature of REPRESENTATIVE	Printed name of REPRESENTATIVE	Date
_____	_____	_____
Signature of ALTERNATIVE REPRESENTATIVE	Printed name of ALTERNATIVE REPRESENTATIVE	Date

For additional legal assistance, contact Disability Rights Oregon

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