# Combined Mental Health Care Declaration and Power of Attorney Form

## Part I. Introduction.

I, _____, having capacity to make mental health decisions, willfully and voluntarily make this declaration and power of attorney 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.

## Part II. Mental Health Declaration.

### 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.

( ) 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:

_____

(Insert name and address of facility)

( ) In the event that I require commitment to a psychiatric treatment facility, I do not wish to be committed to the following facility:

_____

(Insert name and address of facility)

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:

_____

_____

(List medication and reason for exception, preference or limitation)

The exception, preference or limitation applies to generic, brand name and trade name equivalents. I understand that dosage instructions are not binding on my physician.

( ) I do not consent to the use of any medications.

( ) I have designated an agent under the power of attorney portion of this document to make decisions related to medication.

3. Preferences regarding electroconvulsive therapy (ECT).

( ) I consent to the administration of electroconvulsive therapy.

( ) I do not consent to the administration of electroconvulsive therapy.

( ) I have designated an agent under the power of attorney portion of this document to make decisions related to electroconvulsive therapy.

4. Preferences for experimental studies or drug trials.

( ) 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 have designated an agent under the power of attorney portion of this document to make decisions related to experimental studies.

( ) I do not consent to participation in experimental studies.

( ) 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 have designated an agent under the power of attorney portion of this document to make decisions related to drug trials.

( ) I do not consent to participation in any drug trials.

5. 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.

Other matters of importance.

_____
_____
_____
_____
_____
_____

C. Revocation.

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 combined mental health declaration and power of attorney; or

(3) two years after the date this document was executed.

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.

_____
(Specify date)

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:

_____
_____
_____
(Insert name, address, telephone number of the designated person)

(  ) 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.

Part III. Mental Health Power of Attorney.

I, _____, having the capacity to make mental health decisions, authorize my designated health care agent to make certain decisions on my behalf regarding my mental health care. If I have not expressed a choice in this document or in the accompanying declaration, I authorize my agent to make the decision that my agent determines is the decision I would make if I were competent to do so.

A. Designation of agent.

I hereby designate and appoint the following person as my agent to make mental health care decisions for me as authorized in this document. This authorization applies only to mental health decisions that are not addressed in the accompanying signed declaration.

_____

(Insert name of designated person)

Signed: _____

_____

_____

_____

(My name, address, telephone number)

Witnesses' signatures:

_____

_____

Names, addresses, telephone numbers of witnesses:

Witness 1: _____

_____

_____

Witness 2: _____

_____

_____

Agent's acceptance:

I hereby accept designation as mental health care agent for

_____
(Insert name of declarant)

Agent's signature:

_____

Insert name, address, telephone number of designated person:

_____
_____
_____

B. Designation of alternative agent.

In the event that my first agent is unavailable or unable to serve as my mental health care agent, I hereby designate and appoint the following individual as my alternative mental health care agent to make mental health care decisions for me as authorized in this document:

_____
(Insert name of designated person)

Signed: _____

_____

_____
(Witnesses' signatures)

Names, addresses, telephone numbers of witnesses:

Witness 1: _____
_____
_____

Witness 2: _____
_____
_____

Alternative agent's acceptance:

I hereby accept designation as alternative mental health care agent for

_____
(Insert name of declarant)

Alternative agent's signature:

_____

Insert name, address, telephone number:

_____
_____
_____

C. When this power of attorney become effective.

This power of attorney will become effective at the following designated time:

( ) When I am deemed incapable of making mental health care decisions.

( ) When the following condition is met:

_____
(List condition)

D. Authority granted to my mental health care agent.

I hereby grant to my agent full power and authority to make mental health care decisions for me consistent with the instructions and limitations set forth in this document. If I have not expressed a choice in this power of attorney or in the accompanying declaration, I authorize my agent to make the decision that my agent determines is the decision I would make if I were competent to do so.

(1) Preferences regarding medications for psychiatric treatment.

( ) My agent is authorized to consent to the use of any medications after consultation with my treating psychiatrist and any other persons my agent considers appropriate.

( ) My agent is not authorized to consent to the use of any medications.

(2) Preferences regarding electroconvulsive therapy (ECT).

( ) My agent is authorized to consent to the administration of electroconvulsive therapy.

( ) My agent is not authorized to consent to the administration of electroconvulsive therapy.

(3) Preferences for experimental studies or drug trials.

( ) My agent is authorized to consent to my participation in experimental studies if, after consultation with my treating physician and any other individuals my agent deems appropriate, my agent believes that the potential benefits to me outweigh the possible risks to me.

( ) My agent is not authorized to consent to my participation in experimental studies.

( ) My agent is authorized to consent to my participation in drug trials if, after consultation with my treating physician and any other individuals my agent deems appropriate, my agent believes that the potential benefits to me outweigh the possible risks to me.

( ) My agent is not authorized to consent to my participation in drug trials.

E. Revocation.

This power of attorney 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 power of attorney in

the manner specified, I understand that the other instructions contained in this power of attorney will remain effective until:

(1) I revoke this power of attorney in its entirety;

(2) I make a new combined mental health care declaration and power of attorney; or

(3) two years from the date this document was executed. I understand that this power of attorney 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 the power of attorney would expire.

I am making this combined mental health care declaration and power of attorney on the _____ day of _____, 20___

My signature: _____

_____
_____
_____
(My name, address, telephone number)

Witnesses signatures: _____

_____

Names, addresses, telephone numbers of witnesses:

Witness 1: _____
_____
_____

Witness 2: _____
_____
_____

If the principal making this combined mental health care declaration and power of attorney is unable to sign this document, another individual may sign on behalf of and at the direction of the principal.

Signature of person signing on my behalf: _____

_____
_____
_____
(Name, address, telephone number)