DECLARATION FOR MENTAL HEALTH TREATMENT

(IC 16-36-1.5-7)

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 2 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 health care facility as provided by law. 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 do not consent to the administration of the following medications:

_____

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 FACILITY

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

_____ I consent to being admitted to a health care facility for mental health treatment.

_____ I do not consent to being admitted to a health care facility for mental health treatment.

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 2 physicians who will determine whether I am incapable. If that physician is unavailable, that physician's designee shall determine whether I am incapable.

ADDITIONAL REFERENCES OR INSTRUCTIONS

_____

_____

Conditions or limitations:

_____

_____

(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; or

A person related to the principal by blood, marriage or adoption.

Witnessed By:

Witness Signature: _____

Witness Name: _____

Address: _____

Witness Signature: _____

Witness Name: _____

Address: _____

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 3 types of mental health treatment: psychotropic medication, electroconvulsive therapy, and admission to a treatment facility. The instructions that you include in this declaration will be followed only if 2 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 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 when it is communicated to your attending physician 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)

If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.