ADVANCE DIRECTIVE FOR MENTAL HEALTH TREATMENT I, willfully and voluntarily execute this advance directive for mental health treatment. I want the instructions in this advance directive to be followed as described below. **Designated Surrogate** I am naming a surrogate to see that my instructions for mental health treatment are carried out I designate ______ to act as my surrogate. If this person withdraws or is unwilling to act on my behalf, or if I revoke that person's authority to act as my surrogate, I designate to act as my alternate surrogate. The person acting as my surrogate is authorized to act in accordance with the content of this advance directive and may override the advance directive if, and only if, there is substantial medical evidence that failing to do so would result in harm to me. If my instructions and preferences are not stated in the advance directive, the surrogate may act in good faith in making treatment decisions in the manner in which the surrogate believes I would act. I am not naming a surrogate to see that my instructions for mental health treatment

If I do not designate a surrogate, if my surrogate and alternate surrogate withdraw or are unwilling to act on my behalf, or if I revoke their authority to act, then the health care provider and health care facility may proceed to render treatment in accordance with my instructions as described here and in accordance with standards for mental and physical health care.

are carried out.

Psychotropic Medication Provisions

I may indicate below any refusals of treatment with specific psychotropic medications, not to include an entire class of medications, due to factors that may include but are not limited to lack of efficacy, known drug sensitivity, or experience of adverse reaction:

I specifically do not consent and do not authorize my surrogate to consent to the

-	
administration of the following medications or	their respective brand-name or generic
equivalents for the reasons given:	
Specific psychotropic medication	Reason for refusal
I may list below any specific psychotrop	oic medications that I would be willing to
have administered to me if additional medication	ons become necessary:
Specific psychotropic medications:	
Electroconvulsive Therapy Provisions	
Below are my instructions regarding electrocon	vulsive therapy (ECT):
I consent to electroconvulsive therapy (E	ECT) if it is deemed clinically appropriate
to treat my condition.	
I do not consent to electroconvulsive the	rapy (ECT).

Preferred Procedures for Emergency Interventions

I may state preferences for procedures for emergency interventions to be used when necessary for my protection or the protection of others. I understand that I am requesting consideration of my preferences for procedures for emergency interventions but that my surrogate, my health care provider, and the health care facility where I am a patient are not subject to civil liability for not abiding by these preferences. I understand that in the case of possible harm to myself or others, my health care provider or the health care facility may need to use procedures that override my stated preferences. If during an admission or while a patient in a health care facility, it is determined that I am engaging in behavior that requires emergency intervention, my preferences regarding the procedures to be used during an emergency intervention and the order that I prefer the interventions to be used are as follows:

Intervention	Order of Preference	Reason for preference
Seclusion	Trejerence	
Physical restraints		
Seclusion & physical restraint combined		
Medication by injection		
Medication in pill form		
Liquid medication		
Other		
Other		
	•	

Signature of grantor:

Address of grantor:	
In my presence, the grantor volun	tarily dated and signed this writing or directed it
to be dated and signed. I am not the gran	tor's current health care provider, a relative of
the current health care provider, or an ow	rner, operator, employee or relative of an owner
or operator of a health facility in which the	ne grantor is a client or resident.
Signature of witness:	
Signature of witness:	
Surrogate contact information (if designated):	Alternate surrogate contact information (if designated):
Name:	Name:
Address:	Address:
Telephone:	Telephone:
Signed this day of,	Signed this day of,
20	20
Signature of surrogate:	Signature of surrogate: