South Community, Inc.

MENTAL HEALTH ADVANCE DIRECTIVE

For

_____
Name

_____
Address

_____
Address

_____
Phone Number

This form helps you direct your mental health care should your doctor decide that you lack the capacity to make your own medical decisions.

<u>This form is not intended as a substitute for legal advice, and you should contact a lawyer if you have questions about this document.</u>

This document allows you the opportunity to prepare for any time in the future during which you may be unable to make decisions about your mental health care. You may include important personal or medical history, preferences regarding treatment, and/or naming an "agent" who you authorize to make mental health decisions for you.

The provisions of this document becomes in effect only if your attending physician determines that you have lost the capacity to make informed decisions for yourself.

Attempts to comply with treatment preferences will be made whenever possible. These preferences will be followed they are unavailable, inconsistent with reasonable medical care, or in emergent situations.

PERSONAL INFORMATION

History

In addition to what my records might say, I would like practitioners to know the following about the history of my illness:

Diagnosis: _____

Notes about my illness: _____

_____

_____

_____

_____

Symptoms of My Illness

I normally do the things listed below when I become sick:

_____

_____

_____

_____

General Health

Please be aware of the following aspects of my general health/treatment:

_____

_____

_____

_____

_____

DECLARATION OF TREATMENT INSTRUCTIONS

Attending Physician

I name the following doctor as my "attending physician". This physician can make the determination as to whether I have lost the capacity to make informed decisions for myself for the purpose of this document.

Name: _____ Phone: _____
Address: _____

Treatment Providers

In addition to the physician named above, I prefer to be treated by the following mental health professionals, and I instruct my agent to request mental health services for me from the following:

Name: _____ Phone: _____
Address: _____
Specialty: _____

Name: _____ Phone: _____
Address: _____
Specialty: _____

Name: _____ Phone: _____
Address: _____
Specialty: _____

I do **not** wish to be treated by the following doctors or other mental health professionals:

Name: _____ Phone: _____
Address: _____
Specialty: _____

Name: _____ Phone: _____
Address: _____
Specialty: _____

Name: _____ Phone: _____
Address: _____
Specialty: _____

Treatment Facilities

I prefer to be treated at the following facilities:

Name: _____
Address: _____
_____

Name: _____
Address: _____
_____

I prefer **not** to be treated at the following facilities:

Name: _____
Address: _____
_____
Reason to avoid: _____

Name: _____
Address: _____
_____
Reason to avoid: _____

Preferred Treatment

I have listed below my preferences about treatment, including medications and types of therapy:

_____
_____
_____
_____
_____

I have listed below the treatments that have not been helpful and I do ***not*** wish to try them again:

_____
_____
_____

Special Needs

Please respect the following in the way I am cared for:

_____
_____

Additional Legal Documentation

I have a *Durable Health Care Power of Attorney* or *Living Will*. It can be located with the following attorney:

Attorney: _____
Address: _____
_____
Phone: _____

Contacts

In the event of my illness, I would request that the following individuals be contacted:

	Name	**Phone Number**
Psychiatrist:	_____	_____
Primary Care Physician:	_____	_____
Mental Health Provider:	_____	_____
Family/Friends:	_____	_____
	_____	_____
	_____	_____

I would request that the following do ***not*** contact or visit me while I am hospitalized:

_____ _____
_____ _____
_____ _____

APPOINTMENT OF AGENT
(By Proxy)

I appoint the following person(s) to act as my agent to make decisions about my mental health care for me if my attending physician determines that I have lost the capacity to make informed decisions for myself. My agent has the authority to make all mental health care decisions for me, including the right to give, refuse to give, or to withdraw informed consent to any mental health care treatment, as allowed by law.

I instruct my agent to make mental health care decisions for me consistent with my wishes as expressed in this document or as otherwise made known to my agent by me. If my agent does not know and is unable to determine what I want, I instruct my agent to act in what my agent believes to be in my best interest.

I consent to each of the individuals named below to succeed the authority of and serve under this appointment, in the order named, if at any time the prior agent is not readily available or is unwilling to serve or to continue to serve, or is removed by me.

First Choice:
I appoint _____, whose address is _____
_____ Phone Number _____ (day)
_____ (night) to serve as my agent to make all mental health care decisions for me.

Second Choice:
_____, whose address is _____
_____ Phone Number _____ (day)
_____ (night) to serve as my agent to make all mental health care decisions for me.

Third Choice:
_____, whose address is _____
_____ Phone Number _____ (day)
_____ (night) to serve as my agent to make all mental health care decisions for me.

Other Directions to my agent:
_____
_____
_____
_____
_____
_____
_____
_____

REVOCATION OF THIS DOCUMENT

I understand that this document is valid for three years from the date of my signature, unless otherwise indicated below. I can revoke this document at any time by expressing in writing, in any manner, my intention to revoke it. I understand that if I execute a new declaration of treatment for mental health care, the new document will automatically replace this one.

(initial one)

_____ This document has no expiration date and shall not be affected by my disability or by the passage of time

_____ This document shall expire at midnight on the _____ day of _____, 200 __, but otherwise is not affected by my disability or the passage of time.

SIGNATURES

_____	_____	_____
Client Signature	Print Name	Date
_____	_____	_____
Witness Signature	Print Name	Date
_____	_____	_____
Address		Phone
_____	_____	_____
Witness Signature	Print Name	Date
_____	_____	_____
Address		Phone

OR

ACKNOWLEDGEMENT

State of Ohio
County of _____ ss:

On this the _____ day of _____, 200___, before me, the undersigned Notary Public, personally appeared _____, known to me or satisfactorily proven to be the person whose name is subscribed to the above document as the principal, personally appeared before me and acknowledged that (s)he executed this document for the purposes described in the document. I attest that the principal appears to be of sound mind and not under or subject to duress, fraud, or undue influence.

My Commission
Expires: _____ _____
Notary Public