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 as used in this document 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 (check one):

( ) When I am deemed incapable of making mental health care decisions.
( ) When the following condition is met (list condition below):

____

____

B. Treatment Preferences

1. **Choice Of Treatment Facility** (check one):

( ) 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** (check one):

( ) 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.
Please note that any exception, preference or limitation applies to generic, brand name and trade name equivalents and that dosage instructions are not binding.)

( ) 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") (check one):

( ) 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 (check one):

( ) 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 (list below and/or on attached page(s)):

____

____

Examples of other instructions or information that may be included:

Activities that may help or worsen symptoms.

Types of intervention you prefer in the event of a crisis.

Your mental and physical health history; dietary requirements; and religious preferences.

Issues concerning the temporary custody of your children.

Who in your family should be notified and how.

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 one of the following events occurs:

(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 Declaration was executed.

D. Termination

I understand that this Declaration will automatically terminate two years from the date I signed it, unless I am deemed incapable of making mental health care decisions at the time that this Declaration would expire. That termination date is: __________________________.

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 may 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):

____

____

____

____

Please check below as to the desired powers of the guardian:

( ) 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 No.: ____

B. Designation Of Alternative Agent.

In the event that my first choice above 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: ____

My name: ____

Address: ____

____

Telephone No.: ____

Witnesses

Signature:		
Name:		
Address:		
Telephone No.:		

Agent's Acceptance:

I hereby accept designation as the mental health care agent for (insert name of declarant): ______________________________

Signed: ______________________________

Agent's name: ______________________________

Address: ______________________________

____

Telephone No.: ______________________________

Alternative Agent's Acceptance:

I hereby accept designation as the alternative mental health care agent for (insert name of declarant): ______________________________

Signed: ______________________________

Agent's name: ______________________________

Address: ______________________________

____

Telephone No.: ______________________________

C. When This Power Of Attorney Become Effective

This Power of Attorney becomes effective at the following designated time (check one):

( ) When I am deemed incapable of making mental health care decisions.
( ) When the following condition is met (list condition below):

____

____

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 (check one):

( ) 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) (check one):

( ) 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 (check one):

( ) 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 one of the following events:

(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 I signed it 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 _________________, 200____

Signed: ____

My name: ____

Address: ____

____

Telephone No.: ____

Witnesses

Signature:	______________________	______________________
Name:		
Address:		
Telephone No.:		

Note: If the principal making this Combined Mental Health Care Declaration and Power of Attorney is unable to sign this document, s/he may designate another person to do so.

I hereby designate __________________________to sign this Combined Mental Health Care Declaration and Power of Attorney on my behalf of and at my direction.

Signed (by designee): _______________________________________

Designee's name: _______________________________________

Designee's Address: _______________________________________

____

Telephone No.: _______________________________________

MENTAL HEALTH DECLARATION

PART I. INTRODUCTION

I, ________________________ , having capacity to make mental health decisions, willfully and voluntarily make this Declaration 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 as used in this Declaration 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.

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A. **When This Declaration Becomes Effective**

This Declaration becomes effective at the following designated time (check one):

( ) When I am deemed incapable of making mental health care decisions.
( ) When the following condition is met (list condition below):

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B. Treatment Preferences

1. **Choice Of Treatment Facility** (check one):

( ) 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):

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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 (check one):

( ) 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:

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(List medication and reason for exception, preference or limitation. Please note that any exception, preference or limitation applies to generic, brand name and trade name equivalents. I understand that dosage instructions are not binding.)

( ) 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) (check one):

( ) 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 (check one):

( ) 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 (list below and/or on attached page(s)):

____

____

Examples of other instructions or information that may be included:

Activities that may help or worsen symptoms.

Types of intervention you prefer in the event of a crisis.

Your mental and physical health history; dietary requirements; and religious preferences.

Issues concerning the temporary custody of your children.

Who in your family should be notified and how.

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 I take one of the following events occurs:

(1) I revoke this Declaration in its entirety;
(2) I make a new Mental Health Declaration; or
(3) two years after the date I signed this Declaration .

D. Termination

I understand that this Declaration will automatically terminate two years from the date I signed it, unless I am deemed incapable of making mental health care decisions at the time that this Declaration would expire. That termination date is: ________________________.

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 may 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):

____

____

____

____

Please check below as to the desired powers of the guardian:

( ) 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.

I am making this Mental Health Care Declaration on the ___ day of ________________ 200_____.

(Note: If the principal making this Mental Health Care Declaration is unable to sign this document, s/he may designate another person to do so.)

I hereby designate __________________________to sign this Mental Health Care Declaration on my behalf of and at my direction.

Signed by Designee: ____

Designee's name: ______________________________

Address: ______________________________

____

Telephone No.: ______________________________

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, 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. ____________________________

Signed: ____

My name: ____

Address: ____

____

Telephone No.: ____

B. Designation Of Alternative Agent

In the event that my first choice above 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: ____

My name: ____

Address: ____

____

Telephone No.: ____

Witnesses

Signature:		
Name:		
Address:		
Telephone No.:		

Agent's Acceptance:

I hereby accept designation as the mental health care agent for (insert name of declarant): ____________________

Signed: ____________________

Agent's name: ____________________

Address: ____________________

____

Telephone No.: ____________________

Alternative Agent's Acceptance:

I hereby accept designation as the alternative mental health care agent for (insert name of declarant): ____________________

Signed: ____________________

Agent's name: ____________________

Address: ____________________

____

Telephone No.: ____________________

C. When This Power Of Attorney Become Effective (check one):

This Power of Attorney becomes effective at the following designated time (check one):

( ) When I am deemed incapable of making mental health care decisions.
( ) When the following condition is met (list condition below):

____

____

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, 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 (check one):

( ) 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) (check one):

( ) 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 (check one):

( ) 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 one of the following events:

(1) I revoke this Power of Attorney in its entirety;

(2) I make a new Mental Health Power of Attorney; or

(3) two years from the date I signed this document.

I understand that this Power of Attorney will automatically terminate two years from the date I signed it unless I am deemed incapable of making mental health care decisions at the time that the Power of Attorney would expire.

F. Preference As To A Court-Appointed Guardian (optional)

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 may 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):

____

____

____

____

Please check below as to the desired powers of the guardian (check one):

( ) The appointment of a guardian of my person will not give the guardian the power to revoke, suspend or terminate this Power of Attorney.

( ) Upon appointment of a guardian, I authorize the guardian to revoke, suspend or terminate this Power of Attorney.

I am making this Power of Attorney on the ______ day of ________________, 200_____

Signed: ______________________________________

My name: ______________________________________

Address: ______________________________________

____

Telephone No.: ______________________________________

Witnesses

Signature:		
Name:		
Address:		
Telephone No.:		

(Note: If the principal making this Power of Attorney is unable to sign this document, s/he may designate another person to do so.)

I hereby designate __________________________to sign this Power of Attorney on my behalf of and at my direction.

Signed by Designee: ______________________________________

Designee's name: ______________________________________

Address: ______________________________________

____

Telephone No.: ______________________________________