Notice To Person Making a Declaration For Mental Health Treatment

Chapter 137, Title 6, Civil Practice and Remedies Code

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 mental health treatment and specifically three types of mental health treatment: psychoactive medication, convulsive therapy, and emergency mental health treatment. The instructions that you include in this declaration will be followed only if a court believes that you are incapacitated to make treatment decisions. Otherwise, you will be considered able to give or withhold consent for the treatments.

This document will continue in effect for a period of three years unless you become incapacitated to participate in mental health treatment decisions. If this occurs, the directive will continue in effect until you are no longer incapacitated.

You have the right to revoke this document in whole or in part at any time you have not been determined to be incapacitated. YOU MAY NOT REVOKE THIS DECLARATION WHEN YOU ARE CONSIDERED BY A COURT TO BE INCAPACITATED. A revocation is effective when it is communicated to your attending physician or other health care provider.

If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you. This declaration is not valid unless it is signed by two qualified witnesses who are personally known to you and who are present when you sign or acknowledge your signature.

Declaration For Mental Health Treatment

I, _____, being an adult of sound mind, wilfully and voluntarily make this declaration for mental health treatment to be followed if it is determined by a court that my ability to understand the nature and consequences of a proposed treatment, including the benefits, risks, and alternatives to the proposed treatment, is impaired to such an extent that I lack the capacity to make mental health treatment decisions. "Mental health treatment", means electroconvulsive or other convulsive treatment, treatment of mental illness with psychoactive medication, and preferences regarding emergency mental health treatment.

(Optional Paragraph) 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:

_____

_____

Psychoactive Medications

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding psychoactive medications are as follows:

_____I consent to the administration of the following medications:

_____

_____I do not consent to the administration of the following medications:

_____

_____I consent to the administration of a federal Food and Drug Administration approved medication that was only approved and in existence after my declaration and that is considered in the same class of psychoactive medications as stated below:

_____

_____

Conditions or limitations:_____

_____

_____

Convulsive Treatment

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding convulsive treatment are as follows:

_____I consent to the administration of convulsive treatment.

_____I do not consent to the administration of convulsive treatment.

Conditions or limitations:_____

_____

_____

Preferences For Emergency Treatment

In an emergency, I prefer the following treatment FIRST (circle one)
Restraint Seclusion Medication.

In an emergency, I prefer the following treatment SECOND (circle one)
Restraint Seclusion Medication.

In an emergency, I prefer the following treatment THIRD (circle one)
Restraint Seclusion Medication.

_____I prefer a male/female to administer restraint, seclusion, and/or medications.

Options for treatment prior to use of restraint, seclusion, and or medications:

_____

_____

Conditions or limitations:_____

_____

Additional Preferences or Instructions

_____

_____

Conditions or limitations: _____

_____

Signature of Principal/Date: _____

_____

Statement of Witnesses

I declare under penalty of perjury that the principal's name has been represented to me by the principal, that the principal signed or acknowledged this declaration in my presence, that I believe the principal to be of sound mind, that the principal has affirmed that the principal is aware of the nature of the document and is signing it voluntarily and free from duress, that the principal requested that I serve as witness to the principal's execution of this document, and that I am not a provider of health or residential care to the principal, an employee of a provider of health or residential care to the principal, an operator of a community health care facility providing care to the principal, or an employee of an operator of a community health care facility providing care to the principal.

I declare that I am not related to the principal by blood, marriage, or adoption and that to the best of my knowledge I am not entitled to and do not have a claim against any part of the estate of the principal on the death of the principal under a will or by operation of law.

Witness Signature: _____

Print Name: _____

Date: _____

Address: _____

Witness Signature: _____

Print Name: _____

Date: _____

Address: _____