NOTICE TO PERSON MAKING A DECLARATION FOR MENTAL HEALTH TREATMENT

This is an important legal document. It is a declaration that allows, or disallows, mental health treatment. Before signing this document, you should know that:
(1) this document allows you to make decisions in advance about three types of mental health treatment: psychoactive medication, convulsive therapy, and short-term (up to 17 days) admission to a mental health facility;
(2) the instructions that you include in this declaration will be followed only if a court or two physicians believe that you are incapable of otherwise making treatment decisions. Otherwise, you will be considered capable to give or withhold consent for treatment;
(3) you may also appoint a person as your attorney-in-fact to make these treatment decisions for you if you become incapable. The person you appoint has a duty to act consistently with your desires as stated in this document, or, if not state, to make decisions in accordance with what that person believes, in good faith, to be in your best interest. For the appointment to be effective, the person you appoint must accept the appointment in writing. The person also has the right to withdraw from acting as your attorney-in-fact at any time;
(4) this document will continue in effect for a period of three years, unless you become incapable of participating in mental health treatment decisions. If this occurs, the directive will continue in effect until you are no longer incapable;
(5) you have the right to revoke this document in whole or in part, or the appointment of an attorney-in-fact, at any time you have not been determined to be incapable***.*** ***YOU MAY NOT REVOKE THE DECLARATION OR APPOINTMENT WHEN YOU ARE CONSIDERED INCAPABLE BY A COURT OR TWO PHYSICIANS***. A revocation is effective when it is communicated to your attending physician or other provider, and
(6) if there is anything in this document that you do not understand, you should ask an attorney 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.

ADVANCE DIRECTIVE

UTAH
STATE DECLARATION FOR MY MENTAL HEALTH TREATMENT

_____

NAME

_____

SOCIAL SECURITY #

_____

DATE

“THE FORM”

DECLARATION FOR MENTAL HEALTH TREATMENT

A Declaration for Mental Health treatment shall be in substantially the following form:

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 a court or by two physicians that my ability to receive and evaluate information effectively or to communicate my decisions is impaired to such an extent that I lack the capacity to refuse or consent to mental health treatment. “Mental health treatment” means convulsive treatment, treatment with psychoactive medication, and admission to and retention in a mental health facility for a period of up to 17 days.

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:

In the dosages:

_____ considered appropriate by my attending physician.
_____ approved by_____

_____ as I hereby direct:_____

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

_____

_____

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 of the following type:

_____

_____the number of treatments to be:
_____determined by my attending physician.
_____approved by _____
_____as follows: _____
_____I do not consent to the administration of convulsive treatment.

My reasons for consenting to or refusing convulsive treatment are as follows:

_____

_____

ADMISSION TO AND RETENTION IN A MENTAL HEALTH FACILITY

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

_____I consent to being admitted to the following mental health facilities:

_____

_____

I may be retained in the facility for a period of time:

_____ determined by my attending physician.

_____ approved by _____

_____ no longer than _____

This directive cannot, by law, provide consent to retain me in a facility for more than 17 days.

ADDITIONAL REFERENCES OR INSTRUCTIONS

ATTORNEY-IN-FACT

I hereby appoint:
NAME_____

ADDRESS_____

TELEPHONE#_____

to act as my attorney-in-fact to make decisions regarding my mental health treatment if I become incapable of giving or withholding informed consent for that treatment.

If that person named above refuses or is unable to act on my behalf, or if I revoke that person's authority to act as my attorney-in-fact, I authorize person to act as my alternative attorney-in-fact the following:
NAME_____

ADDRESS_____

TELEPHONE#_____

My attorney-in-fact is authorized to make decisions, which are consistent with the wishes I have expressed in this declaration. If your wishes are not expressed, my attorney-in-fact is to act in good faith according to what he or she believes to be in my best interest.

Signature of Declarant Date

AFFIRMATION OF WITNESSES

We affirm that the declarant is personally known to us, that the declarant signed or acknowledged the declarant's signature on this declaration for mental health treatment in our presence, that the declarant appears to be of sound mind and does not appear to be under duress, fraud, or undue influence. Neither of us is the person appointed as attorney-in-fact by this document, the attending physician, an employee of the attending physician, an employee of the Division of Mental Health within the Department of Human Services, an employee of a local mental health authority, or an employee of any organization that contracts with a local mental health authority.

Witnessed by:

Signature of Witness Date Printed Name of Witness

Signature of Witness Date Printed Name of Witness

ACCEPTANCE OF APPOINTMENT AS ATTORNEY-IN-FACT

I accept this appointment and agree to serve as attorney-in-fact to make decisions about mental health treatment for the declarant. I understand that I have a duty to act consistently with the desires of the declarant as expressed in the declaration. I understand that this document gives me authority to make decisions about mental health treatment only while the declarant is incapable as determined by a court or two physicians. I understand that the declarant may revoke this appointment, or the declaration, in whole or in part, at any time and in any manner, when the declarant is not incapable.

Signature of Attorney-in-Fact	Date	Printed Name

Signature of Alternate Attorney-in-Fact	Date	Printed Name