COMBINED MENTAL HEALTH CARE DECLARATION AND POWER OF ATTORNEY

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.

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 when I am deemed incapable of making mental health care decisions for myself.

B. Treatment Preferences.

1. Preferences regarding medications for psychiatric treatment.

I consent to the medications that my treating physician recommends.

2. Preferences regarding electroconvulsive therapy (ECT).

I do not consent to the administration of electroconvulsive therapy.

3. Preferences for experimental studies or drug trials.

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 consent to participation in drug trials if my treating physician believes that the potential benefits to me outweigh the possible risks to me.

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 power of attorney in the manner specified, I understand that the

other instructions contained in this power of attorney will remain effective until:

(1) I revoke this declaration in its entirety;
(2) I make a new combined mental health care declaration and power of attorney; or
(3) two years after the date this document was executed.

D. Termination.

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

_____
Date of Signing

E. Preferences as to a Court-Appointed Guardian.

In the event a court decides to appoint a guardian, I desire the following person to be appointed:

_____
_____
_____

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

Part III. Mental Health Care 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.

_____

Signed:

_____
_____ (address)
_____ (city, state, zip)
_____
Home Phone: _____ Work Phone: _____

Witnessed by:

_____ _____
_____ _____
_____ _____
_____ _____

Agent's Acceptance:

I hereby accept designation as mental health care agent for _____.

Agent's Signature and Address:

_____
_____
_____
_____

B. Designation of Alternate Agent.

In the event that my first agent 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:

_____

Signed:

_____
_____
_____
_____
Home Phone: _____ Work Phone: _____

Witnessed by:

_____ _____
_____ _____
_____ _____
_____ _____

Agent's Acceptance:

I hereby accept designation as mental health care agent for _____.

Alternative Agent's Signature:

_____
_____
_____
_____, ___ _____

C. When this Power of Attorney Becomes Effective.

This power of attorney will become effective when I am deemed incapable of making mental health care decisions for myself.

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 power of attorney. 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.

My agent is authorized to consent to the use of any medications after consultation with my treating psychiatrist and any other person my agent considers appropriate.

2. Preferences regarding electroconvulsive therapy (ECT).

My agent is not authorized to consent to the administration of electroconvulsive therapy.

3. Preferences for experimental studies or drug trials.

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 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.

F. 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:

(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 of execution 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 _____.

My Signature:

_____
_____ address
_____ city
_____ county
_____ state, zip code
Home Phone: _____ Work Phone: _____

Witnesses signatures and addresses:

_____ _____
_____ _____
_____ _____
_____ _____