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How to Complete Your Illinois Declaration for Mental Health Treatment

Declaration for Mental Health Treatment (Mental Health Treatment Preference Declaration Act, 755 ILCS 43)

INSTRUCTIONS — KEEP FOR YOUR RECORDS. DO NOT ATTACH THIS PAGE TO YOUR DOCUMENT.

About this form. This Illinois declaration lets you decide in advance whether you want **psychotropic medication, electroconvulsive treatment, or short-term admission** to a facility if a mental health crisis leaves you unable to decide, and lets you name someone to decide for you.

1. **Read the Notice (Pages 5–6)**
   The Notice at the end explains what this declaration does and how long it lasts. Read it before you fill in anything.
2. **Make your choices (Pages 1–2)**
   For each treatment, initial whether you consent or do not consent, and add any conditions. You may choose a physician to help decide whether you are incapable.
3. **Name an attorney-in-fact (Page 3, optional)**
   Name a trusted adult to make these decisions for you, plus an alternate. Each must sign the acceptance on Page 4 for the appointment to work.
4. **Sign with two witnesses (Page 3)**
   Illinois requires two adult witnesses who know you personally. They cannot be your attorney-in-fact, your doctor or mental health provider, or a relative. We can provide qualified witnesses for an additional fee, and we recommend adding the notary acknowledgment on Page 4.

After It's Signed

- Give copies to your doctors, mental health providers, attorney-in-fact, and any facility where you receive care, so it becomes part of your medical record.
- The declaration lasts three years. If you are incapable when it would expire, it continues until you are capable again.
- Revoking it requires a written statement signed by you and a physician, as shown on the last page.

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Have questions about this document? To consult with an attorney, contact **Gavrilov & Brooks Law Firm** at **(916) 504-0529** or **www.gavrilovlaw.com**.

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DECLARATION FOR MENTAL HEALTH TREATMENT

(Mental Health Treatment Preference Declaration Act, 755 ILCS 43)

I,

Name of principal

being an adult of sound mind, willfully and voluntarily make this declaration for mental health treatment to be followed if it is determined by two physicians or the court that my ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that I lack the capacity to refuse or consent to mental health treatment. "Mental health treatment" means electroconvulsive treatment, treatment of mental illness with psychotropic medication, and admission to and retention in a health care facility for a period 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:

PSYCHOTROPIC MEDICATIONS

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

☐ I consent to the administration of the following medications:

☐ I do not consent to the administration of the following medications:

Conditions or limitations:

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ELECTROCONVULSIVE TREATMENT

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

☐ I consent to the administration of electroconvulsive treatment.

☐ I do not consent to the administration of electroconvulsive treatment.

Conditions or limitations:

ADMISSION TO AND RETENTION IN A HEALTH CARE FACILITY

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

☐ I consent to being admitted to a health care facility for mental health treatment.

☐ I do not consent to being admitted to a health care facility for mental health treatment.

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

Conditions or limitations:

SELECTION OF PHYSICIAN (OPTIONAL)

If it becomes necessary to determine if I have become incapable of giving or withholding informed consent for mental health treatment, I choose

Dr. (name) of (practice or address)

to be one of the two physicians who will determine whether I am incapable. If that physician is unavailable, that physician's designee shall determine whether I am incapable.

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ADDITIONAL REFERENCES OR INSTRUCTIONS

Conditions or limitations:

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 the 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 the following person to act as my attorney-in-fact:

Name | Address | Telephone

My attorney-in-fact is authorized to make decisions that are consistent with the wishes I have expressed in this declaration or, if not expressed, as are otherwise known to my attorney-in-fact. If my wishes are not expressed and are not otherwise known by my attorney-in-fact, my attorney-in-fact is to act in what he or she believes to be my best interest.

X _____ Signature of principal | Date

AFFIRMATION OF WITNESSES

We affirm that the principal is personally known to us, that the principal signed or acknowledged the principal's signature on this declaration for mental health treatment in our presence, that the principal appears to be of sound mind and not under duress, fraud or undue influence, that neither of us is:

- A person appointed as an attorney-in-fact by this document;
- The principal's attending physician or mental health service provider or a relative of the physician or provider;
- The owner, operator, or relative of an owner or operator of a facility in which the principal is a patient or resident; or
- A person related to the principal by blood, marriage or adoption.

Witnessed by:

X _____ Signature of witness | Printed name of witness | Date

X _____ Signature of witness | Printed name of witness | Date

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

X _____
Signature of attorney-in-fact

Printed name

Date

X _____
Signature of alternate attorney-in-fact

Printed name

Date

OPTIONAL NOTARY ACKNOWLEDGMENT (recommended)

STATE OF ILLINOIS)
COUNTY OF) SS.

This instrument was acknowledged before me on

(date)

by (name of principal)

and by the witnesses

Witness

Witness

X _____
Notary Public

(Notary seal)

Notary's printed name

My commission expires

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NOTICE TO PERSON MAKING A DECLARATION FOR MENTAL HEALTH TREATMENT

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 three types of mental health treatment: psychotropic medication, electroconvulsive therapy, and short-term (up to 17 days) admission to a treatment facility. The instructions that you include in this declaration will be followed only if 2 physicians or the court believes that you are incapable of making treatment decisions. Otherwise, you will be considered capable to give or withhold consent for the treatments.

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 consistent with your desires as stated in this document or, if your desires are not stated or otherwise made known to the attorney-in-fact, to act in a manner consistent with what the person in good faith believes 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.

This document will continue in effect for a period of 3 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.

You have the right to revoke this document in whole or in part at any time you have been determined by a physician to be capable of giving or withholding informed consent for mental health treatment. A revocation is effective when it is communicated to your attending physician in writing and is signed by you and a physician. The revocation may be in a form similar to the following:

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REVOCATION

I,

Name of principal

willfully and voluntarily revoke my declaration for mental health treatment as indicated:

☐ I revoke my entire declaration.

☐ I revoke the following portion of my declaration:

X _____

Signature of principal Date

I, Dr.

Name of physician

have evaluated the principal and determined that he or she is capable of giving or withholding informed consent for mental health treatment.

X _____

Signature of physician Date

If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you. This declaration will not be valid unless it is signed by 2 qualified witnesses who are personally known to you and who are present when you sign or acknowledge your signature.

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