

Principal Name: \_\_\_\_\_

Advance Directives for Mental Health Treatment  
*(Please refer to the Psychiatric Advance Directives Toolkit for instructions to complete this form.)*

1. Symptom(s) I might experience during a period of crisis:

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2. Medication instructions.

A. I agree to administration of the following medication(s):

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B. I do not agree to administration of the following medication(s):

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C. Other information about medications (allergies, side effects)

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**3. Facility Preferences.**

A. I agree to admission to the following hospital(s):

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B. I do not agree to admission to the following hospital(s):

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C. Other information about hospitalization:

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**4. Emergency Contacts in case of mental health crisis:**

**Name:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**Home Phone #** \_\_\_\_\_  
**Work Phone #** \_\_\_\_\_  
**Relationship to Me:** \_\_\_\_\_

**Name:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**Home Phone #** \_\_\_\_\_  
**Work Phone #** \_\_\_\_\_

Principal Name: \_\_\_\_\_

Relationship to Me: \_\_\_\_\_

Psychiatrist: \_\_\_\_\_

Work Phone # \_\_\_\_\_

Case Manager/Therapist: \_\_\_\_\_

Work Phone # \_\_\_\_\_

**5. Crisis Precipitants. The following may cause me to experience a mental health crisis:**

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**6. Protective Factors. The following may help me avoid a mental health crisis:**

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**7. Response to Hospital. I usually respond to the hospital as follows:**

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**8. Preferences for Staff Interactions.**

**Staff of the hospital or crisis unit can help me by doing the following:**

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**Staff can minimize use of restraint and seclusion by doing the following:**

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**9. I give permission for the following people to visit me in the hospital:**

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**10. The following are my preferences about ECT:**

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**11. Other Instructions.**

**If I am hospitalized, I want the following to be taken care of at my home:**

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**I understand that the information in this document may be shared by my mental health treatment provider with any other mental health treatment provider who may serve me when necessary to provide treatment in accordance with this advance instruction. Other instructions about sharing of information are as follows:**

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Principal Name: \_\_\_\_\_

**12. Legal documentation for Advance Directives:**

**Signature of Principal**

By signing here, I indicate that I am mentally alert and competent, fully informed as to the contents of this document, and understand the full impact of having made this advance instruction for mental health treatment.

Signature of Principal \_\_\_\_\_ Date \_\_\_\_\_

**Nature of Witnesses**

I hereby state that the principal is personally known to me, that the principal signed or acknowledged the principal's signature on this advance instruction for mental health treatment in my presence; that the principal appears to be of sound mind and not under duress, fraud, or undue influence; and that I am not:

The attending physician or mental health service provider or an employee of the physician or mental health treatment provider;

An owner, operator, or employee of an owner or operator of a health care facility in which the principal is a patient or resident; or

Related within the third degree to the principal or to the principal's spouse.

**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 advance instruction for mental health treatment in our presence, that the principal appears to be of sound mind and not under duress, fraud, or undue influence, and 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:

Witness: \_\_\_\_\_ Date \_\_\_\_\_

Witness: \_\_\_\_\_ Date \_\_\_\_\_

STATE OF NORTH CAROLINA, COUNTY OF \_\_\_\_\_

(to be notarized on the following page)

**Certification of Notary Public**

Principal Name: \_\_\_\_\_

STATE OF NORTH CAROLINA  
COUNTY OF \_\_\_\_\_

I, \_\_\_\_\_, a Notary Public for the County cited above in the State of North Carolina, hereby certify that \_\_\_\_\_ appeared before me and swore or affirmed to me and to the witnesses in my presence that this instrument is an advance instruction for mental health treatment, and that he/she willingly and voluntarily made and executed it as his/her free act and deed for the purposes expressed in it.

I further certify that \_\_\_\_\_ and \_\_\_\_\_, witnesses, appeared before me and swore or affirmed that they witnessed \_\_\_\_\_ sign the attached advance instruction for mental health treatment, believing him/her to be of sound mind; and also swore that at the time they witnessed the signing they were not (i) the attending physician or mental health treatment provider or an employee of the physician or mental health treatment provider and (ii) they were not an owner, operator, or employee of an owner or operator of a health care facility in which the principal is a patient or resident, and (iii) they were not related within the third degree to the principal or to the principal's spouse. I further certify that I am satisfied as to the genuineness and due execution of the instrument.

This is the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

Notary Public \_\_\_\_\_

My Commission expires: \_\_\_\_\_

### Statutory Notices

**Notice to Person Making an Instruction For Mental Health Treatment.** This is an important legal document. It creates an instruction for mental health treatment. Before signing this document you should know these important facts: This document allows you to make decisions in advance about certain types of mental health treatment. The instructions you include in this declaration will be followed if a physician or eligible psychologist determines that you are incapable of making and communicating treatment decisions. Otherwise you will be considered capable to give or withhold consent for the treatments. Your instructions may be overridden if you are being held in accordance with civil commitment law. Under the Health Care Power of Attorney you may also appoint a person as your health care agent to make treatment decisions for you if you become incapable. You have the right to revoke this document at any time you have not been determined to be incapable. **YOU MAY NOT REVOKE THIS ADVANCE INSTRUCTION WHEN YOU ARE FOUND INCAPABLE BY A PHYSICIAN OR OTHER AUTHORIZED MENTAL HEALTH TREATMENT PROVIDER.** A revocation is effective when it is communicated to your attending physician or other provider. The physician or other provider shall note the revocation in your medical record. To be valid, this advance instruction must be

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signed by two qualified witnesses, personally known to you, who are present when you sign or acknowledge your signature. It must also be acknowledged before a notary public.

**Notice to Physician or Other Mental Health Treatment Provider.** Under North Carolina law, a person may use this advance instruction to provide consent for future mental health treatment if the person later becomes incapable of making those decisions. Under the Health Care Power of Attorney the person may also appoint a health care agent to make mental health treatment decisions for the person when incapable. A person is "incapable" when in the opinion of a physician or eligible psychologist the person currently lacks sufficient understanding or capacity to make and communicate mental health treatment decisions. This document becomes effective upon its proper execution and remains valid unless revoked. Upon being presented with this advance instruction, the physician or other provider must make it a part of the person's medical record. The attending physician or other mental health treatment provider must act in accordance with the statements expressed in the advance instruction when the person is determined to be incapable, unless compliance is not consistent with G.S. 122C-74(g). The physician or other mental health treatment provider shall promptly notify the principal and, if applicable, the health care agent, and document noncompliance with any part of an advance instruction in the principal's medical record. The physician or other mental health treatment provider may rely upon the authority of a signed, witnessed, dated, and notarized advance instruction, as provided in G.S. 122C-75. (1997-442, s. 2; 1998-198, s. 2; 1998-217, s. 53(a)(5).)