

STATE OF NORTH CAROLINA

**ADVANCE INSTRUCTION FOR  
MENTAL HEALTH TREATMENT**

COUNTY OF \_\_\_\_\_

***(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 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.)*

I, \_\_\_\_\_, being an adult of sound mind, willfully and voluntarily make this advance instruction for mental health treatment to be followed if it is determined by a physician or eligible psychologist 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 the process of providing for the physical, emotional, psychological, and social needs of the principal. "Mental health treatment includes electroconvulsive treatment (ECT), commonly referred to as "shock treatment", treatment of mental illness with psychotropic medication, and admission to and retention in a facility for care or treatment of mental illness.

I understand that under G.S. 122C-57, other than for specific exceptions stated there, mental health treatment may not be administered without my express and informed written consent or, if I am incapable of giving my informed consent, the express and informed consent of my legally responsible person, my health care agent named pursuant to a valid health care power of attorney, or my consent expressed in this advance instruction for mental health treatment. I understand that I may become incapable of giving or withholding informed consent for mental 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 instructions regarding psychoactive medications are as follows: *(Place initials beside choice.)*

\_\_\_\_\_ I consent to the administration of the following medications:

\_\_\_\_\_

\_\_\_\_\_ I do not consent to the administration of the following medications:

\_\_\_\_\_

Conditions or limitations: \_\_\_\_\_

\_\_\_\_\_

ADMISSION TO AND RETENTION IN FACILITY

If I become incapable of giving or withholding informed consent for mental health treatment, my instructions regarding admission to and retention in a health care facility for mental health treatment are as follows: *(Place initials beside choice.)*

\_\_\_\_\_ I consent to being admitted to a health care facility for mental health treatment. My facility preference is

\_\_\_\_\_.

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

This advance instruction cannot, by law, provide consent to retain me in a facility for more than ten (10) days.

Conditions or limitations: \_\_\_\_\_

\_\_\_\_\_

ADDITIONAL INSTRUCTIONS

These instructions shall apply during the entire length of my incapacity. In case of mental health crisis, please contact:

1. Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Telephone Number: \_\_\_\_\_

Work Telephone Number: \_\_\_\_\_

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

2. Name: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
Home Telephone Number: \_\_\_\_\_  
Work Telephone Number: \_\_\_\_\_  
Relationship to Me: \_\_\_\_\_
3. My Physician:  
Name: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_
4. My Therapist:  
Name: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_

The following may cause me to experience a mental health crisis:

\_\_\_\_\_

The following help me avoid a hospitalization:

\_\_\_\_\_

I generally react to being hospitalized as follows:

\_\_\_\_\_

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

\_\_\_\_\_

I give permission for the following person or people to visit me:

\_\_\_\_\_

Instructions concerning any other medical interventions, such as electroconvulsive (ECT) treatment (commonly referred to as "shock treatment:

\_\_\_\_\_

Other instructions:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ (Initial if applicable) I have attached an additional sheet of instructions to be followed and considered part of this advance instruction.

SHARING OF INFORMATION BY PROVIDERS

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:

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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.

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Date

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Signature of Principal

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:

- a. The attending physician or mental health service provider or an employee of the physician or mental health treatment provider;
- b. 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
- c. Related within the third degree to the principal or to the principal's spouse.

AFFIRMATION OF WITNESS

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

Witnessed by:

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

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

CERTIFICATION OF NOTARY PUBLIC

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

\_\_\_\_\_  
Notary Public  
My Commission Expires: \_\_\_\_\_