* 1 5 3 0 3 *

ACT Health

Advance Consent Direction

Pursuant to Section 27 of the *Mental Health Act 2015*

Complete details or affix label

URN: _____

Family name: _____

Given names: _____

DOB: _____ Gender: _____

An Advance Consent Direction can be completed on an electronic template or handwritten on a printed form downloaded from the Clinical Forms Register. Please attach extra pages if needed.

An Advance Consent Direction is for those who have decision making capacity and have consulted with their treating team about options for treatment, care or support.

An Advance Consent Direction that does not include Electroconvulsive Therapy (ECT) must be made in writing and be signed by the person in the presence of a witness who is not a treating health professional, and by the witness in the presence of the person, and signed by the representative of the person's treating team.

It outlines your preferences regarding your **mental health treatment** if you are too unwell to be able to make decisions. You may choose to complete some or all sections of this form.

Please note: Your Advance Consent Direction will be taken into account when making decisions about treatment, care and support.

This Advance Consent Direction belongs to:

Name: _____

Address: _____

Date of birth: ___ /___ /___

I **consent** to the following if I become unwell and unable to make decisions due to mental illness or mental disorder: *(for conditions other than mental health, complete an Advanced Care Plan)*

Treatment:	
Care:	
Support:	
Medication:	
Procedure:	

Advance Consent Direction

I **do not consent** to the following if I become unwell and unable to make decisions due to mental illness or mental disorder:

Medication:	
Procedure:	

I **consent** to the following people being provided information about my treatment, care or support required for mental disorder or mental illness, if I become unwell and unable to make decisions due to mental illness or mental disorder:

Name	Contact details	Relationship to you

I **do not consent** to the following people being provided information about my treatment, care or support required for mental disorder or mental illness, if I become unwell and unable to make decisions due to mental illness or mental disorder:

Name	Contact details	Relationship to you

Signature of person making the Advance Consent Direction _____ Date _____

Signature of witness (not treating health professional) _____ Print name (witness) _____ Date _____

Signature of representative of treating team _____ Date _____

Signature of witness (not treating health professional) _____ Print name (witness) _____ Date _____

You may end this Advance Consent Direction at any time (provided it is deemed by the Treating Team you have the capacity to do so).

I end the Advance Consent Direction listed above, effective:

☐ immediately

☐ from (insert date) ____ /____ /____

Signature of person making the Advance Consent Direction _____ Date _____

* 1 5 3 0 3 *

ACT Health

Advance Consent Direction

Pursuant to Section 27 of the *Mental Health Act 2015*

Complete details or affix label

URN: _____

Family name: _____

Given names: _____

DOB: _____ Gender: _____

ADVANCE CONSENT DIRECTION – ELECTROCONVULSIVE THERAPY (*ECT)*

ONLY COMPLETE THIS SECTION IF ECT IS A TREATMENT OF CHOICE WITHIN THE ADVANCE CONSENT DIRECTION

I **consent** to ECT being administered to me – not more than 9 times as treatment for my mental illness or mental disorder if I become unwell and unable to make decisions due to mental illness or mental disorder.

Signature of person making the Advance Consent Direction _____ Date _____

Signature of witness (1) (not treating health professional) _____ Print name (witness 1) _____ Date _____

Signature of witness (2) (not treating health professional) _____ Print name (witness 2) _____ Date _____

Signature of representative of treating team _____ Print name _____ Designation _____ Date _____

Signature of witness (1) (not treating health professional) _____ Print name (witness 1) _____ Date _____

Signature of witness (2) (not treating health professional) _____ Print name (witness 2) _____ Date _____

You may end this Advance Consent Direction at any time (provided you are well enough to make decisions).

I end the Advance Consent Direction listed above, effective:

☐ immediately

☐ from (insert date) ____ /____ /____

Signature of person making the Advance Consent Direction _____ Date _____

The completed form must be included on the electronic clinical record

A copy of this form has been provided to:

☐ Yes	The Person	☐ Yes ☐ N/A	Power of Attorney
☐ Yes ☐ N/A	Guardian	☐ Yes ☐ N/A	Nominated Person
☐ Yes ☐ N/A	Any member of the person's treating team who does not have access to the person's record		

Signature _____ Print name _____ Designation _____ Date _____