# **‘Mental Health Advance Choice Document’**

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| This document provides brief details about myself, my illness, treatments which work/don’t work and any other important issues which must be considered when I am unwell. I would like this document to be used by healthcare professionals if I become severely unwell, to help them understand my illness and help guide their healthcare decisions.*(Note on filling the form out: Please delete examples and guidance notes provided in the boxes if you would like. These are just examples to help guide you through the document)*  |
| **Personal details** |
| Name |  |
| Date of Birth |  |
| Health Identification Number (e.g., NHS number) if known |  |
| Home address |  |
| Phone number |  |
| Email address |  |
| **If I become severely unwell, please contact the following people:** |
| Relationship to me | Name | Contact details | Are you happy for information to be given to this person by your healthcare team? |
| Family member/friend |  |  |  |
| Mental health team |  |  |  |
| GP or family doctor |  |  |  |
| *Other* |  |  |  |
| **Mental health issues/diagnoses / current treatments** |
| Give indication of main mental health problems and any medications etc. you are currently using. |
| **‘Who I am’ - Important information about me for those who will be looking after me:** |
| Give a few brief details about the things which are most important for others to know about you. For example, you might include:* Relationship status
* Dependents (e.g., children, adults, or pets that I care for)
* Religion/faith (if this is important to you)
* Gender/sexuality
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| **Physical health issues/diagnoses** |
| If applicable include pregnancy/recent childbirth in this section and include details of current treatment for physical health conditions. |
| **More information about my medical history can be found:** |
| *Mental health records/ GP records/ Family member/friend* |
| **Details of other legal documents about my health** |
| *e.g. physical heath advance statements/Advance Decisions to Refuse Treatment/Lasting Power of Attorney for Health and Welfare* |
| **Signs that I am becoming severely unwell and reasons why I need urgent treatment** |
| Relapse indicators, risks of not getting urgent treatment |
| **My preferences for treatment when severely unwell** |
| Give details of medical treatments/doses or other types of care which have been most successful or unsuccessful in past episodes – try to be as specific as possible. |
| **Alternative suggestions for treatment if your preferences are unavailable** |
| *Give suggestions of other treatments which have been helpful in the past or which might be helpful in future.* |
| **Preferences for treatment at home or in hospital** |
| *E.g. where you would prefer to be treated / anything you have found helpful/unhelpful during previous episodes of severe illness.* |
| **Care for others if I am severely unwell** |
| Preferred alternative care arrangements and needs of children or other dependents / pets |
| **My Signature** |
| I confirm I am aged 18 or over and intend that this document remains valid until I make it clear that my wishes have changed. |
| Name |  |
| Signature |  |
| Date of signing |  |