Mental Health Crisis Advance Directive

Personal Information

Full Name

Date of Birth

Address

Phone Number

Email

Emergency Contact

Name

Phone

Relationship

Healthcare Agent / Advocate

Name

Phone

Relationship

Preferred Facilities/Providers

Hospital, Clinic, or Provider

Medications

Current Medications

Medication Allergies

Treatment Preferences

Describe any treatment preferences, including methods that help you during a crisis

What Helps / What Does Not Help

What helps me during a crisis

What does not help/is not effective

Other Instructions

Additional information or instructions

Signature

Date