Form CR-A
[See Regulation 3(1)]

ADVANCE DIRECTIVE FOR MENTAL ILLNESS TREATMENT

Patient Details

Full Name _____ Date of Birth _____ Contact Number _____

Father's/ Mother's Name _____ Address

Advance Directives

I wish to be cared for and treated under

I wish not to be cared for and treated under

Any history of allergies, known side effects, or other medical problems

Nominated Representatives

Representative (1)

Full Name _____ Date of Birth _____ Contact Number _____

Father's/ Mother's Name _____ Address

Representative (2)

Full Name _____ Date of Birth _____ Contact Number _____

Father's/ Mother's Name _____ Address

Signature of Nominated Representative

First Nominated Representative

Name _____ Signature _____ Date _____

Second Nominated Representative

Name _____ Signature _____ Date _____

☐ I understand that the Advance Directive will become valid only when I lose my capacity to make treatment related decisions. I have appointed the above persons in order of precedence(Enclosed photo ID and age proof), who are **above 18 years of age** to act as my Nominated Representatives to make decisions about my mental illness treatment, when I am incapable to do so

Name _____ Signature _____ Date _____

Signature of Witness

_____ has made advance directive of his/her own free will and has signed it in our presence

Witness (1) Name _____ Signature _____ Date _____

Witness (2) Name _____ Signature _____ Date _____

Declaration

I, Dr/Mr/Ms. _____ ,(registered mental health professional/medical practitioner/ MHRB Member) hereby certify that, Mr/Ms _____ has the mental capacity to make a valid advanced directive as per the evaluation on (Date and Time) _____

Name _____ Signature _____ Date _____