

**ADVANCE STATEMENT
MADE UNDER THE
MENTAL HEALTH (CARE AND TREATMENT) (SCOTLAND) ACT 2003**

1. Name of person making this statement: _____

Address of person: _____

Date of Birth: _____

2. I _____ [name] wish the following views to be taken into account, in the event of decisions about my care and treatment being made under the Mental Health (Care and Treatment) (Scotland) Act 2003, and my being unable to express my views about my care and treatment at that time.

3. I would like to state my wishes regarding the following treatments:

Medication - (MAOI) - I HAVE BEEN TREATED WITH THIS GROUP OF MEDICINES, MANY TIMES IN THE PAST AND HAVE HAD SEVERE ISSUES WITH MAINTAINING MY WEIGHT. I WOULD NOT WANT TO BE TREATED WITH THIS TYPE OF MEDICATIONS BECAUSE OF THE SEVERE DIETARY RESTRICTIONS ASSOCIATED WITH THEM.

I AM ALSO AWARE THAT THE ANAESTHETIC COMPLICATIONS, ASSOCIATED WITH THESE MEDICATIONS COULD IMPACT ON POTENTIAL DECISIONS REGARDING OTHER TREATMENT OPTIONS (ECT)

ECT - I HAVE HAD ECT MANY TIMES PREVIOUSLY AND FOUND IT TO BE USEFUL, HOWEVER I WOULD LIKE THIS TO BE ONLY CONSIDERED AS AN OPTION OF LAST RESORT IN ORDER TO SAVE MY LIFE.

PSYCHOLOGY / PSYCHOTHERAPY - I VALUE PSYCHOLOGY INPUT INTO MY RECOVERY FROM CRISIS AND THE ONGOING SELF-MANAGEMENT OF MY MENTAL HEALTH. WHEN UNWELL I COMPLETELY ISOLATE MYSELF FROM OTHERS BUT I SIGNIFY THAT I AM OPENING MYSELF UP TO PSYCHOLOGICAL THERAPIES, WILL BE THAT I HAVE BEEN TO ENGAGE OR INTERACT WITH OTHERS ON THE HAND. I DON'T FUNCTION WELL IN GROUP PSYCHOLOGICAL THERAPIES SO WOULD PREFER ONE TO ONE.

MY NOMINATED NAMED PERSON IS MRS [REDACTED]
WHO IS MY SUTGE, (SEE NAMED PERSON SHEET FOR DETAILS)

I WOULD LIKE ALL INFORMATION RELEVANT TO MY
CURRENT ADMISSION TO BE SHARED + DISCUSSED
WITH HER, EVEN IF I SHOULD ATTEMPT TO WITHDRAW
THIS NOMINATION + CONSENT WILIT UNWELL

IF I SHOULD BE ADMITTED AS A VOLUNTARY PATIENT,
I WOULD STILL LIKE THIS ADVANCE STATEMENT
TO BE ACKNOWLEDGED AND, WHERE POSSIBLE, ADHERED
TO.

(Please note when compiling this list you may wish to express both positive and negative views on treatments, e.g. those treatments which work well for you and those that are less effective.

In addition your reasons for your stated position are also important: e.g. an adverse reaction to a particular medication.)

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4. Signature [REDACTED]
Date of Advance Statement: [REDACTED]

5. Witness Certificate
I certify that in my opinion [REDACTED] [insert name of person making
advance statement] has the capacity of properly intending the wishes set out above.

I hereby witness his/her signature [REDACTED] 25/9/13.
[signature] [date of witnessing signature]

Full name of witness: [REDACTED]
Address of witness: [REDACTED]

Designation of witness: CONSULTANT PSYCHIATRIST.

[Occupation/category which enables the witness to act as a 'prescribed person']

You should keep a list of the names of everyone who has a copy of this statement.

Please also note that the entire statement should be accompanied by your signature – please print double sided.