PHYSICIAN NAME: FACILITY: ADDRESS: CITY: ZIP: TELEPHONE NO.:	*FOR COURT USE ONLY*
SUPERIOR COURT OF CALIFORNIA, COUNTY OF SAN DIEGO ☐ CENTRAL DIVISION, CENTRAL COURTHOUSE, 1100 UNION ST., SAN DIEGO, CA 92101 ☐ CENTRAL DIVISION, FAMILY COURT, 1555 6TH AVE., SAN DIEGO, CA 92101	
IN THE MATTER OF	
PATIENT AT	
TREATING PHYSICIAN'S DECLARATION REGARDING CAPACITY OF PATIENT TO CONSENT TO OR REFUSE ANTIPSYCHOTIC MEDICATION	D.O.B.

I,_____, a physician licensed to practice medicine in the State of California, declare:

1. I am the treating physician for the referenced patient.
2. The patient is currently being involuntarily detained in the mental health facility identified above pursuant to Welf. & Inst. Code § 5000. The patient ☐ is ☐ is not involuntarily detained on a 30-day hold pursuant to Welf. & Inst. Code §§ 5270.10-5270.65.
3. In my professional opinion, the patient is presently showing symptoms of a mental disorder known as:

   _____ as evidenced by the following:

   a. Statements: _____

   _____

   _____

   _____

   b. and/or Behaviors: _____

   _____

   _____

   _____

   _____
4. In my professional opinion, the patient would benefit from the administration of the following antipsychotic medications as broadly defined by Welf. & Inst. Code § 5008 (I):_____

   _____
5. I have discussed or attempted to discuss the proposed treatment with the patient on the following dates and times:

Date	Time	Date	Time	Date	Time	Date	Time

6. I told the patient the following information about the risks, benefits, and alternatives to the treatment: _____

   Risks: _____

   _____

   Benefits: _____

   _____

   Alternatives: _____

   _____

   a. The patient ☐ was ☐ was not given a written advisement regarding the probable effects and side effects of the medication.

   b. On the dates listed in Item 5 above, and any additional dates and times of attempted discussions about medication and treatment, in response to the information I provided, the patient said or did the following:

   _____

   _____

   _____

   _____

   _____

   _____

   c. I replied to the patient's responses as follows: _____

   _____

   _____

   _____

   _____

   _____

   d. The patient ☐ has ☐ has not objected to the proposed medication because of allergies or side effects from prior administrations of the proposed or related medication.

      i. If the patient objected to the proposed medication because of allergies or side effects from prior administrations of the proposed or related medication, please describe the specific concerns the patient raised: _____

      _____

      _____

      ii. I conducted the following investigation of the objection(s): _____

      _____

      _____

      iii. Based on my investigation of information referenced in section (i) above, I made the following changes in recommended treatment: _____

      _____

      _____

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7. The patient ☐ does ☐ does not believe he/she suffers from a mental disorder. I base my conclusion on the following statements and/or actions by the patient: _____

8. Without regard to the patient's belief that he/she does (or does not) have a mental disorder, the patient ☐ does ☐ does not understand his/her situation. I base my conclusion on the following statements and/or actions by the patient: _____

9. The patient ☐ is ☐ is not able to understand the risks and benefits of medication or alternative treatments. I base my conclusions on the following statements and/or actions of the patient: _____

10. The patient ☐ is ☐ is not able to understand and evaluate the risks, benefits and alternatives to the proposed treatment by means of rational thought processes or otherwise participate in the medication decision. I base my conclusion on the following statements and /or actions by the patient: _____

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11. During this hospitalization, the patient ☐ was ☐ was not treated with antipsychotic medication over his/her objection. If the patient was treated with antipsychotic medication over his/her objection, the antipsychotic medication was administered on the following dates and for the reasons indicated below:

Date(s)	Reason(s) for emergent medication
_____	_____
_____	_____
_____	_____
_____	_____

Date: _____ _____

Treating Physician

VERIFICATION

I, the undersigned, state that I am the declarant and treating physician in the above-entitled matter. I have read the foregoing **Treating Physician's Declaration Regarding Capacity of Patient to Consent to or Refuse Antipsychotic Medication** and know its contents, and the same is true of my personal knowledge, except as to matters which are stated upon my information and belief, and as to those matters, I believe them to be true.

I declare under penalty of perjury pursuant to the laws of the State of California that the above is true and correct.

Executed this_____ of _____at _____, California

_____

Signature of Treating Physician

_____

Printed Name of Treating Physician

Clear This Form