**CAUSE NO. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**THE STATE OF TEXAS FOR THE § IN THE \_\_\_\_\_\_\_\_\_ COURT OF**

 **§**

**BEST INTEREST AND PROTECTION §**

 **§**

**OF \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (initials only) § \_\_\_\_\_\_\_\_\_ COUNTY, TEXAS**

**APPLICATION FOR ORDER TO ADMINISTER PSYCHOACTIVE MEDICATION**

THE HONORABLE JUDGE OF SAID COURT:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, M.D./D.O., Applicant files this application pursuant to TEX. HEALTH & SAFETY CODE ANN. § 574.104, seeking an order to authorize the administration of psychoactive medication to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Patient, and respectfully shows that:

**I.**

 [ ]  Patient is subject to an order dated \_\_/\_\_/\_\_\_\_, for court-ordered inpatient mental health services; or

 [ ]  an application for court-ordered mental health services has been filed and Applicant requests that this Application be heard on the same date as the Application for Court-Ordered Mental Health Services.

**II.**

 The current order or application provides for or requests services under:

 [ ]  TEX. HEALTH & SAFETY CODE ANN. § 574.034 (temporary inpatient); or

 [ ]  TEX. HEALTH & SAFETY CODE ANN. § 574.035 (extended inpatient)

**III.**

 Applicant has diagnosed Patient with the following condition(s):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**IV.**

 Applicant has determined that the administration of the following classes of psychoactive medications, as marked on “Exhibit A”, is the proper course of treatment for and in the best interest of the Patient.

**V.**

 Applicant believes the Patient lacks the capacity to make a decision regarding the administration of psychoactive medication for the following reasons:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**VI.**

 Applicant believes that if the Patient is treated with the class(es) of psychoactive medication specified in paragraph IV above, Patient’s prognosis is:

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**VII.**

 Applicant believes that if the Patient is treated with the class(es) of psychoactive medication specified in paragraph IV above, the Patient’s prognosis is:

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**VIII.**

 Applicant has considered the following alternatives to psychoactive medications for treatment of the Patient:

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**IX.**

 Applicant has determined that the alternatives listed in paragraph VII will not be as effective as the administration of psychoactive medication for the following reasons:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**X.**

 \*\*Please fill this section out or attach General Information Sheet\*\*

1. Social Worker’s or Doctor’s name, address, telephone, and/or cell phone number:
2. Patient’s Unit (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Patient’s gender: \_\_\_\_\_\_\_\_\_\_
4. Patient’s age and date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Patient’s DL# or State-issued ID: (either give the number or indicate with your initials that you were unable to ID)

Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **OR** Initial if unable to ID: \_\_\_\_\_\_\_\_\_

1. Patient’s SSN#: (either give the number or indicate with your initials that you were unable to ID)

Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **OR** Initial if unable to ID: \_\_\_\_\_\_\_\_\_

1. Patient’s race: ( ) Asian ( ) Black ( ) Caucasian ( ) Hispanic

( ) Other ( ) Unknown

1. If the patient is a minor or the subject of a guardianship, the parent(s), managing conservator(s), or guardian(s), and their address for service:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. **Who is responsible for costs and expenses?** *Please complete this section.*

[ ]  Hospital; indicate name of hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Healthcare District [ ]  County (County where proceedings are pending)

[ ]  \*\*Other County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***If a County other than (county where proceedings pending) is guaranteeing costs, give County name above, and add the following information below:*** (1) Person you spoke with, (2) Court and court number represented, (3) telephone number, and (4) when contacted **\*\* Attach paperwork from transferring county\*\***

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**PRAYER**

 WHEREFORE, Applicant requests that the Court:

1. Appoint an attorney to represent the Patient;
2. Set a hearing on this Application to be held not later than thirty (30) days after the date this Application is filed;
3. Direct the Clerk of the Court to issue a Notice of Hearing and copy this Application to be served upon the Patient immediately after the time of the hearing is set;
4. Direct the Clerk of the Court to issue a Notice of Hearing to Applicant immediately after the time of hearing is set;
5. Upon hearing, enter an order, pursuant to TEX. HEALTH & SAFETY CODE ANN.

§574.106, authorizing the Texas Department of State Health Services to administer the class(es) of psychoactive medication specified in paragraph IV of this Application to the Patient, regardless of the Patient’s refusal.

“My name is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_: I am over the age of 21; and my

address is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

United States. I declare under penalty of perjury that the foregoing is true and correct.”

Executed in \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_County, State of Texas, on the \_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 202\_\_.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 SIGNATURE OF APPLICANT