EMERGENCY AND INVOLUNTARY MEDICATION POLICY
APPENDIX: Sample Forms

CF-01-1 - “Notice of Advocacy Services”

CF-01-2 - “Notice to Patient’s Advocate of Involuntary Medication Procedures”

CF-01-3 - “Decision of Hearing Officer on Involuntary Medication”

CF-01-4 - “Decision of Conservator on the Administration of Involuntary Medication”

CF-01-5 – “Notice to Court of Involuntary Medication Procedures Pursuant to CGS 17a-543a”

CF-01-6 – “Notice to Patient’s Advocate of Involuntary Medication Procedures Pursuant to CGS 17a- 543a”

CF-01-7 – “Decision of Special Limited Conservator on the Administration of Involuntary Medication”

Form CF-01-1

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

Patient Name ________________

FACILITY NAME

MPI#: ______________

Unit (or other location information):

Print or Addressograph Imprint

NOTICE OF ADVOCACY SERVICES

YOU HAVE THE RIGHT TO ADVOCACY SERVICES AND STAFF AT THIS FACILITY WILL HELP YOU ACCESS THOSE SERVICES.

THIS NOTICE IS BEING GIVEN TO YOU AT THIS TIME BECAUSE:

- ☐ **You are being admitted to the facility.**
  All patients receive a Notice of Advocacy Services upon admission to [FACILITY NAME].
- ☐ **Your doctor is seeking a second opinion about your ability to give informed consent to medication for the treatment of your psychiatric illness**
- ☐ **Your doctor is applying for a court order to appoint a conservator of person who will have authority to consent to administration of medicine for you without your specific consent**
- ☐ **Your doctor is applying for a court order to appoint a special limited conservator who will have authority to consent to administration of medicine for you without your specific consent**
- ☐ **Your doctor is requesting an internal hearing to seek authority to provide you with medication without your specific consent**
- ☐ **Other (Specify)**:____

YOU MAY CHOOSE ANY PERSON YOU WANT TO BE YOUR ADVOCATE

(YOU MUST SIGN A RELEASE TO ALLOW STAFF TO CONTACT THE ADVOCATE FOR YOU)

☐ I confirm receipt of the "NOTICE OF ADVOCACY SERVICES"

☐ I choose______________________________as my advocate, and have signed a release to notify my chosen advocate.

Patient Signature Date | Patient (Print Name)

Witness Signature Date | Witness (Print Name)

Patient has refused to sign this form.

Staff Signature Date Staff (Print Name)

ORIGINAL – Chart (*Legal Section*) **COPY** – Patient *and* Send Copy to Conservator if Applicable

The following advocates are available to you:

Facility Patient Advocates *[Employees of the facility who have the responsibility to investigate complaints and concerns from clients, advocate for clients, and work to resolve concerns]* [add local contact information]	**Connecticut Legal Rights Project (CLRP)** *[An independent free legal service agency representing DMHAS clients; lawyers and paralegals are available to clients]* [add local contact information]
Connecticut Community for Addictions Recovery *[A private non-profit group that advocates for persons in addictions recovery & provides recovery support services]* Phone: Local: 860-244-CCAR (2227) Fax: 860-244-2228 Toll free in CT: 1-800-708-9145 198 Wethersfield Ave. Hartford, CT 06114	**Disability Rights Connecticut (DRCT)** *[A statewide non-profit organization with a mission to advocate for the human, civil, and legal rights of people with disabilities in Connecticut.]* Phone: (860) 297-4300 Fax: (860) 296-0055 Toll free in CT: (800) 842-7303 846 Wethersfield Ave. Hartford, CT 06114

YOU MAY CHOOSE ANY PERSON YOU WANT TO BE YOUR ADVOCATE

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

NOTICE TO PATIENT'S ADVOCATE

OF INVOLUNTARY MEDICATION PROCEDURES

Date ____

Patient Name____Unit/Location _________________

Name of Patient's Chosen Advocate: ____

Advocate's Address, phone, fax:

Patient has signed a written consent for release of information to the advocate. circle: YES NO

If YES, proceed with below.

This is to inform you that the following action is being initiated:

1. ☐ The treating psychiatrist (*Name*) ____ ____has requested that another psychiatrist consult on the need for involuntary medication.

2. ☐ A petition is being filed with the Probate Court to appoint a conservator of the person with the authority to make medication decisions for the above-named patient.

3. ☐ An application is being filed with the Probate Court to extend the authority of the conservator to make medication decisions for 120 days.

4. ☐ A petition is being filed with the Probate Court for involuntary medication of a patient capable of informed consent but who poses a direct threat of harm.

5. ☐ A petition is being filed with the Probate Court to extend authority for 120 days for involuntary medication of a patient capable of informed consent but who poses a direct threat of harm.

☐ A determination has been made that an internal involuntary medication hearing be held for the above-named patient.

ORIGINAL – Chart (*Legal Section*)
Send/FAX COPY to identified Advocate

Form CF-01-3
11/1/2011

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

DECISION OF HEARING OFFICER ON INVOLUNTARY MEDICATION

Instructions: Print Clearly or Type

Name of Patient______________________________Unit _____

Date of Hearing ____

Attendees (Participants/Capacities –*i.e*. Patient Advocate, Psychiatrist) ______________________________

Hearing Officer ____

____

____

____

1. [ ] The patient **is not** capable of providing informed consent. (*Complete Item 2*)
   [ ] The patient **is** capable of providing informed consent. (*Complete Item 3*)

2. I hereby find that the patient is: a.) incapable of informed consent and b.) the medication is medically appropriate and c.) the patient is rapidly deteriorating; and d.) the provision of such medication would not violate an advance health care directive. ***State reasons for each of the above conclusions***.

____

____

____

3. I hereby find that the patient: a) while capable of providing informed consent, is refusing to accept medically appropriate medication, and b.) the patient poses a direct threat of harm to self or others, and c.) there is no less intrusive beneficial treatment; and d.) without medication, the patient's direct threat of harm will continue unabated. ***State reasons for each of the above conclusions.***

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____

____

On the basis of the foregoing, I find that the patient:

[ ] **may be** involuntarily medicated for a period not to exceed 30 days.

[ ] **may not be** involuntarily medicated.

Date of Decision______________________ Signature of Hearing Officer___________________________

Print Name: ____

Notice of Appeal Rights: If you are dissatisfied with the decision in this case, you may file an application for an expedited hearing in the local Probate Court, which will hear the case within fifteen (15) days. For assistance with this process or further information, you may contact your advocate.

ORIGINAL – Chart (*Legal Section*)
PHOTO COPIES to: Patient, Advocate, Facility Medical Director, Attending Psychiatrist

Form CF-01-4
11/1/2011

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

DECISION OF CONSERVATOR ON THE ADMINISTRATION OF INVOLUNTARY MEDICATION

As the conservator authorized by the Probate Court to consent to the administration of medication for

____
(*Name of Patient*)

I hereby confirm that I have carried out the following responsibilities, as required by Sec. 17a-543(e)(l) of the Connecticut General Statutes:

1. Met with the patient and the physician;
2. Reviewed the patient's written record;
3. Considered the risks and benefits from the medication, the likelihood and seriousness of adverse side effects, the preferences of the patient, the patient's religious views, and the prognosis with and without medication.

After consideration of all the information listed above, I have decided that:

[ ] I **consent** to the administration of medication as indicated.

Specify types(s): ____
____
____
____

[ ] I **do not** consent to the administration of medication.

Conservator Signature__________________________ Date ____________________________________

Printed Name:______________________________ Telephone ________________________________

ORIGINAL – Chart (*Legal Section*) **PHOTO COPY** to – Conservator

Form CF-01-5
11/1/2011

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

NOTICE TO COURT OF INVOLUNTARY MEDICATION PROCEDURES

PURSUANT TO CGS 17a-543a

Date ____

Patient Name ____

Docket #(s): ____

Clerk of Court, address, phone, fax:

Defense Counsel, address, phone, fax:

State's Attorney, address, phone, fax:

This is to inform you that the following action is being initiated:

1. ☐ The treating psychiatrist (*Name*) ____ has requested that another psychiatrist consult on the need for involuntary medication.

2. ☐ A petition is being filed with the Probate Court to appoint a Special Limited Conservator with the authority to make medication decisions for the above-named patient.

3. ☐ An application is being filed with the Probate Court to extend the authority of the Special Limited Conservator to make medication decisions for 120 days.

4. ☐ A petition is being filed with the Probate Court for involuntary medication of a patient capable of informed consent but who poses a direct threat of harm.

5. ☐ A petition is being filed with the Probate Court to extend authority for 120 days for involuntary medication of a patient capable of informed consent but who poses a direct threat of harm.

ORIGINAL – Chart (*Legal Section*)

Form CF-01-6
11/1/2011

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

NOTICE TO PATIENT'S ADVOCATE OF INVOLUNTARY MEDICATION PROCEDURES PURSUANT TO CGS 17a-543a

Date ____

Patient Name____Unit/Location _________________

Name of Patient's Chosen Advocate: ____

Advocate's Address, phone, fax:

Patient has signed a written consent for release of information to the advocate. circle: YES NO

If YES, proceed with below.

This is to inform you that the following action is being initiated:

1. ☐ The treating psychiatrist (*Name*) ____ has requested that another psychiatrist consult on the need for involuntary medication.

2. ☐ A petition is being filed with the Probate Court to appoint a Special Limited Conservator with the authority to make medication decisions for the above-named patient.

3. ☐ An application is being filed with the Probate Court to extend the authority of the Special Limited Conservator to make medication decisions for 120 days.

4. ☐ A petition is being filed with the Probate Court for involuntary medication of a patient capable of informed consent but who poses a direct threat of harm.

5. ☐ A petition is being filed with the Probate Court to extend authority for 120 days for involuntary medication of a patient capable of informed consent but who poses a direct threat of harm.

ORIGINAL – Chart (*Legal Section*)

Send/FAX COPY to identified Advocate

Form CF-01-7 11/1/2011

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

DECISION OF SPECIAL LIMITED CONSERVATOR ON THE ADMINISTRATION OF INVOLUNTARY MEDICATION

As the Special Limited Conservator authorized by the Probate Court to consent to the administration of medication for

____

(*Name of Patient*)

I hereby confirm that I have carried out the following responsibilities, as required by Sec. 17a-543a(a)(l) of the Connecticut General Statutes:

1. Met with the patient and the physician;
2. Reviewed the patient's written record;
3. Considered the risks and benefits from the medication, the likelihood and seriousness of adverse side effects, the preferences of the patient, the patient's religious views, and the prognosis with and without medication.

After consideration of all the information listed above, I have decided that:

[ ] I **consent** to the administration of medication as indicated.

Specify types(s): ____

____

____

____

____

____

[ ] I **do not** consent to the administration of medication.

Conservator Signature__________________________ Date ______________________________

Printed Name______________________________ Telephone __________________________

ORIGINAL – Chart (*Legal Section*) **PHOTO COPY** to – Special Limited Conservator