SUPERIOR COURT OF CALIFORNIA, COUNTY OF RIVERSIDE

☐ **PALM SPRINGS** 3255 E. Tahquitz Canyon Wy., Palm Springs, CA 92262
☐ **TEMECULA** 41002 County Center Dr., Ste. 100, Temecula, CA 92591
☐ **RIVERSIDE** 4050 Main St., Riverside, CA 92501

RI-PR052

ATTORNEY OR PARTY WITHOUT ATTORNEY (*Name, State Bar Number and Address)*	*FOR COURT USE ONLY*
TELEPHONE NO.: FAX NO. *(Optional):* E-MAIL ADDRESS *(Optional)*: ATTORNEY FOR *(Name)*:	
IN THE MATTER OF:	CASE NUMBER:

DECLARATION OF TREATING PHYSICIAN REGARDING CAPACITY TO CONSENT TO OR REFUSE ANTIPSYCHOTIC MEDICATION (WELFARE AND INSTITUTIONS CODE § 5332)

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 held at the above facility under Welfare and Institutions Code § 5000 et seq.

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

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

4. The patient is presently showing symptoms of a mental disorder known as

5. The symptoms of this diagnosis that the patient is currently experiencing are:

6. In my professional opinion, the patient would benefit from the administration of the following antipsychotic medications (for each drug, list name, dose, route, frequency, and probable length of time the medication will be taken):

7. On date: _____ , I provided the patient with written information addressing the probable effects and the possible side effects of the medication(s).

IN THE MATTER OF:	CASE NUMBER:

8. 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)

9. I explained or attempted to explain the proposed treatment to the patient, as well as the following information:

   a. Probable effects of the medication:

   b. Possible side effects of the medication:

   c. The likelihood of improving or not improving without the medication:

   d. Reasonable alternative treatments available:

10. The patient's response to my explanation was as follows:

11. 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.

    a. 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:

    b. I ☐ have ☐ have not obtained the patient's medication history.

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

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IN THE MATTER OF:	CASE NUMBER:

12. 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:

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

14. The patient ☐ is ☐ is not able to rationally understand and evaluate information regarding informed consent, and otherwise participate in the treatment decision. I base my conclusions on the following statements and/or actions by the patient:

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

Date: _____ _____

(SIGNATURE OF TREATING PHYSICIAN)

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