Ref. 755 ILCS 43

DECLARATION FOR MENTAL HEALTH TREATMENT

I, _____ , being an adult of sound mind,

(printed name)

willfully and voluntarily make this declaration for mental health treatment to be followed if it is determined by 2 physicians or the court that my ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that I lack the capacity to refuse or consent to mental health treatment. "Mental health treatment" means electroconvulsive treatment, treatment of mental illness with psychotropic medication, and admission to and retention in a health care facility for mental treatment for a period of up to 17 days.

I understand that I may become incapable of giving or withholding informed consent for mental health treatment due to the symptoms of a diagnosed mental disorder. These symptoms may include:

PSYCHOTROPIC MEDICATIONS

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding psychotropic medications are as follows:

☐ I consent to the following medications:

☐ I do not consent to the following medications:

Conditions or limitations:

ELECTROCONVULSIVE TREATMENT

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding electroconvulsive treatment are as follows:

☐ I consent to the administration of electroconvulsive treatment.

☐ I do not consent to the administration of electroconvulsive treatment.

Conditions or limitations:

ADMISSION TO AND RETENTION IN FACILITY

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding admission and retention in a mental health facility are as follows:

☐ I consent to being admitted to a health care facility for mental health treatment.

☐ I do not consent to being admitted to a health facility for mental health treatment.

This directive cannot, by law, provide consent to detain me in a facility for more than 17 days.

Conditions or limitations:

SELECTION OF PHYSICIAN (OPTIONAL)

If it becomes necessary to determine if I have become incapable of giving or withholding informed consent or mental health

treatment, I choose Dr. _____ of _____

to be one of the 2 physicians who will determine whether I am incapable. If that physician is unavailable, that physician's designee shall determine whether I am incapable.

ADDITIONAL REFERENCES OR INSTRUCTIONS

Conditions or limitations:

ATTORNEY-IN-FACT

I hereby appoint:

NAME _____

ADDRESS _____

(street) (city) (state) (zip) (telephone number)

to act as my attorney-in-fact to make decisions regarding my mental health treatment if I become incapable of giving or withholding informed consent for that treatment.

If the person named above refused or is unable to act on my behalf, or if I revoke that person's authority to act as my attorney-in-fact, I authorize the following to act as my attorney-in-fact:

NAME _____

ADDRESS _____

(street) (city) (state) (zip) (telephone number)

My attorney-in-fact is authorized to make decisions that are consistent with the wishes I have expressed in this declaration or, if not expressed, are otherwise known to my attorney-in-fact. If my wishes are not expressed and are not otherwise known by my attorney-in-fact, my attorney-in-fact is to act in what he or she believes to be my best interest.

_____ _____

(Signature of principal) (Date)

AFFIRMATION OF WITNESSES

We affirm that the principal is personally known to us, that the principal signed or acknowledged the principal's signature on this declaration for mental health treatment in our presense, that the principal appears to be of sound mind and not under duress, fraud or undue influence, that neither of us is:

A person appointed as attorney-in-fact by this document;

The principal's attending physician or mental health service provider or a relative of the physician or provider;

The owner, operator, or relative of an owner or operator of a facility in which the principal is a patient or resident; or

A person related to the principal by blood, marriage or adoption.

Witnessed by:

(Signature of witness)	(Date)	(Printed name of witness)
(Signature of witness)	(Date)	(Printed name of witness)

ACCEPTANCE OF APPOINTMENT AS ATTORNEY-IN-FACT

I accept this appointment and agree to serve as attorney-in-fact to make decisions about mental health treatment for the principal. I understand that I have a duty to act consistent with the desires of the principal as expressed in this appointment. I understand that this document gives my authority to make decisions about mental health treatment only while the principal is incapable as determined by a court or 2 physicians. I understand that the principal may revoke this declaration at any time and in any manner when the principal is not incapable.

(Signature of witness)	(Date)	(Printed name of witness)
(Signature of witness)	(Date)	(Printed name of witness)

REVOCATION OF DECLARATION FOR MENTAL HEALTH TREATMENT

I, _____ , willfully and voluntarily revoke my declaration for mental health
(printed name)
treatment as indicated:

☐ I revoke my entire declaration

☐ I revoke the following portion of my declaration:

Date: _____ Signed: _____
(Signature of principal)

I, Dr. _____ , have evaluated the principal and determined that he or she is capable of giving or withholding informed consent for mental health treatment.

Date: _____ Signed: _____
(Signature of principal)

If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you. This declaration will not be valid unless it is signed by 2 qualified witnesses who are personally known to you and who are present when you sign or acknowledge your signature.

I provided the above - named individual with a copy of this Revocation in ☐ English ☐ Spanish
☐ Other _____ at the individual's request.
(Specify)

_____ _____ on _____
Name Title Date

PETITION FOR INVOLUNTARY/JUDICIAL ADMISSION

STATE OF ILLINOIS

CIRCUIT COURT FOR THE _____ JUDICIAL CIRCUIT

_____COUNTY

IN THE MATTER OF

)
)
)
)
)
)

Docket No. _____

_____

(name of respondent)

Who is asserted to be a person subject to _____ In-patient admission to a facility and for whom

(judicial/involuntary)

this petition is being initiated by reason of: (Select one or more, if applicable)

☐ Emergency inpatient admission by certificate; (405 ILCS 5/3-600). The Respondent is currently detained in a mental health facility or hospital; name of facility where detained: _____ .

☐ Inpatient admission by court order; (405 ILCS 5/3-700).

☐ Voluntary admittee submitted written notice of desire to be discharged and two Certificates are attached to/submitted with this petition; (405 ILCS 5/3-403).

☐ Voluntary admittee failed to reaffirm a desire to continue treatment and two Certificates are attached to/submitted with this petition; (405 ILCS 5/3-404).

☐ Person continues to be subject to involuntary admission on an inpatient basis; (405 ILCS 5/3-813).

☐ Emergency admission of the developmentally disabled; (405 ILCS 5/4-400).

☐ Judicial admission of the developmentally disabled; (405 ILCS 5/4-500).

☐ Developmentally disabled person or an interested person on behalf of a person submitted written objection to admission; (405 ILCS 5/4-306).

☐ Administrative person; (or person who executed application) failed to authorize continued residence; (405 ILCS 5/4-310).

☐ Person continues to meet standard for judicial admission; (405 ILCS 5/4-611).

I assert that _____ is: (check all that apply)

☐ a person with mental illness who: because of his or her illness is reasonably expected, unless treated on an inpatient basis, to engage in conduct placing such person or another in physical harm or in reasonable expectation of being physically harmed;

☐ a person with mental illness who: because of his or her illness is unable to provide for his or her basic physical needs so as to guard himself or herself from serious harm without the assistance of family or others, unless treated on an inpatient basis;

☐ a person with mental illness who: refuses treatment or is not adhering adequately to prescribed treatment; because of the nature of his or her illness is unable to understand his or her need for treatment; and if not treated on an inpatient basis, is reasonably expected based on his or her behavioral history, to suffer mental or emotional deterioration and is reasonably expected, after such deterioration, to meet the criteria of either paragraph one or paragraph two above.

☐ an individual who: is developmentally disabled and unless treated on an in-patient basis is reasonably expected to inflict serious physical harm upon himself or herself or others in the near future, and/or

☐ in need of immediate hospitalization for the prevention of such harm.

I base the foregoing assertion on the following (State in detail the signs and symptoms of mental illness displayed by the Respondent. Include prior diagnosis, treatment and hospitalizations. Describe any threats, behavior or pattern of behavior which support your complaint. Include personal observations that lead to your belief the Respondent is subject to involuntary admission): If additional space needed please attach a separate page or pages.

Below is a list of all witnesses by whom the facts asserted may be proven (include addresses and phone numbers):

Listed below are the names and addresses of the spouse, parent, guardian, or substitute decision maker, if any, and close relative or, if none, a friend of the respondent whom I have reason to believe may know or have any of the other names and addresses. If names and addresses are not listed below, I made a diligent inquiry to identify and locate these individuals and the following describes the specific steps taken by me in making this inquiry (additional pages may be attached as necessary):

○ I do ○ I do not have a legal interest in this matter.

○ I do ○ I do not have a financial interest in this matter.

○ I am ○ I am not involved in litigation with the respondent.

☐ Although I have indicated that I have a legal or financial interest in this matter or that I am involved in litigation with the respondent, I believe it would not be practicable or possible for someone else to be the petitioner for the following reasons:

☐ No certificate was attached with this petition because no physician, qualified examiner or clinical psychologist was immediately available or it was impossible after diligent effort to obtain a certificate. However: I believe, as a result of my personal observation, that the respondent is subject to Involuntary inpatient admission. A diligent effort was made to obtain a certificate; but no physician, qualified examiner or clinical psychologist could be found who has examined or could examine the respondent; and
a diligent effort has been made to convince the respondent to appear voluntarily for examination by a physician, qualified examiner or clinical psychologist, or I reasonably believe that effort would impose a risk of harm to the respondent or others.

☐ One Certificate of Examination is attached.

☐ Two Certificates of Examination are attached.

Did a peace officer detain respondent, take him/her into custody, and/or transport him/her to the mental health facility?

☐ No ☐ Yes; If yes, the peace officer **MAY** complete the petition or if the petition IS NOT COMPLETED by the peace officer transporting the person, the following information MUST be entered:

Transporting Officer's Name: _____ Badge Number: _____

Employer: _____

The petitioner can request to be notified if the facility director approves the recipients's request for voluntary or informal admission prior to adjudication. The petitioner may also request to be notified of the recipient's discharge under section 3-902 (d) of the Mental Health and Developmental Disabilities Code. Failure to indicate a choice will be treated as a decision NOT to be notified.

☐ if the individual requests and is approved for voluntary or informal admission prior to adjudication, I wish to be notified using the contact information supplied below. (Hospital staff use form IL462-2203 for notification purposes).

☐ if the individual is committed or discharged by court, I wish to be notified using the contact information supplied below. (Hospital staff use form IL462-2208M for notification purposes).

☐ I do not wish to be notified in either of the two situations described above.

The petitioner has made a good faith attempt to determine whether the recipient has executed a power of attorney for health care under the Powers of Attorney for Health Care Law or a declaration for mental health treatment under the Mental Health Treatment Preference Declaration Act and to obtain copies of these instruments if they exist.
I have read and understood this petition and affirm that the statements made by me are true to the best of my knowledge.
I further understand that knowingly making a false statement on this Petition is a Class A Misdemeanor.

Date: _____ Signed: _____

Time: _____ Printed Name: _____

Address:

Relationship to Respondent:

_____

Telephone Number: _____

Within 12 hours of admission to the facility under this status I gave the respondent a copy of this Petition (IL462-2005). I have explained the Rights of Admittee to the respondent and have provided him or her with a copy of it. I have also provided him or her with a copy of Rights of Individuals Receiving Mental Health and Developmental Services (IL462-2001) and explained those rights to him or her (405 ILCS 5/3-609).

Date/Time of Admission _____

To Mental Health Facility/Psychiatric Unit

Signed: _____

Printed Name: _____

Title: _____

RIGHTS OF ADMITTEE

1. If you have been brought to this facility on the basis of this petition alone, you will not be immediately admitted, but will be detained for examination. You must be examined by a qualified professional within 24 hours or be released.

2. When you are first examined by a physician, clinical psychologist, qualified examiner, or psychiatrist, you do not have to talk to the examiner. Anything you say may be related by the examiner in court on the issue of whether you are subject to involuntary or judicial admission.

3. At the time that you have been certified you will be admitted to the facility and a copy of the petition and certificate will be filed with the court. A copy of the petition shall also be given to you.

4A. If you are alleged to be subject to involuntary admission (mentally ill) you must also be examined within 24 hours excluding Saturdays, Sundays, and holidays by a psychiatrist (different from the first examiner) or be released. If you are alleged to be subject to involuntary admission the court will set the matter for a hearing.

4B. If you are alleged to be subject to judicial admission (developmentally disabled) the court will set a hearing upon receipt of the diagnostic evaluation which is required to be completed within 7 days.

5A. If you are alleged to be subject to involuntary admission (mentally ill) and if the facility director approves, you may be admitted to the facility as a voluntary admittee upon your request any time prior to the court hearing.

The court may require proof that voluntary admission is in your best interest and in the public interest.

5B. If you are alleged to be subject to judicial admission (developmentally disabled) and if the facility director approves, you may decide that you prefer to admit yourself to the facility rather than have the court decide whether you ought to be admitted. You may make the request for administrative admission at any time prior to the hearing. The court may require proof that administrative admission is in your best interest and the public interest.

6. You have the right to request a jury.

7. You have the right to request an examination by an independent physician, psychiatrist, clinical psychologist, or qualified examiner of your choice. If you are unable to obtain an examination, the court may appoint an examiner for you upon your request.

8. You have the right to be represented by an attorney. If you do not have funds or are unable to obtain an attorney, the court will appoint an attorney for you.

9. You have the right to be present at your court hearing.

10. As a general rule, you do not lose any of your legal rights, benefits, or privileges simply because you have been admitted to a mental health facility (see your copy of the "Rights of Individuals"). However, you should know that persons admitted to mental health facilities will be disqualified from obtaining Firearm Owner's Identification Cards, or may lose such cards obtained prior to admission.

11. Information about the health care services you receive at a mental health or developmental disabilities facility is protected by privacy regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (P.O. 104-191) at 45 CFR 160 and 164. Your personally identifiable health information will only be used and/or released in accordance with HIPAA and the Illinois Mental Health and Development Disabilities Confidentiality Act [740 ILCS 110].

A Guardianship and Advocacy Commission is a state agency consisting of three divisions: Legal Advocacy Services, Human Rights Authority and the Office of the State Guardian. The Commission is located at the following addresses:

East Central Regional Office
2125 S. First Street
Champaign, IL 61820
Phone: (217) 278-5577
Fax: (217) 278-5588

Peoria Regional Office
401 N. Main Street, Suite 620
Peoria, IL 61602
Phone: (309) 671-3030
Fax: (309) 671-3060

Rockford Regional Office
4302 N. Main Street, Suite 108
Rockford, IL 61103
Phone: (815) 987-7657
Fax: (815) 987-7227

Egyptian Regional Office
47 Cottage Drive
Anna, Illinois 62906-1669
Phone: (618) 833-4897
Fax: (618) 833-5219

West Suburban Regional Office
Madden Mental Health Center
1200 S. First Avenue, P.O. Box 7009
Hines, IL 60141
Phone: (708) 338-7500
Fax: (708) 338-7505

Metro East Regional Office
Holly Bldg., 4500 College
Suite 100
Alton, IL 62002
Phone: (618) 474-5503
Fax: (618) 474-5517

North Suburban Regional Office
9511 Harrison Avenue
Des Plaines, Illinois 60016
Phone: (847) 294-4264
Fax: (847) 294-4263

Chicago Regional Office
160 N. La Salle Street
Suite S500
Chicago, IL 60601
Phone: (312) 793-5900
Fax: (312) 793-4311

Springfield Regional Office
521 Stratton Building
401 S. Spring Street
Springfield, IL 62706
Phone: (217) 785-1540
Fax: (217) 524-0088

Equip for Equality, Inc. is an independent, not-for-profit organization that administers the federal protection and advocacy system to people with disabilities in Illinois. Equip for Equality, Inc., provides self-advocacy assistance, legal services, education, public policy advocacy, and abuse investigations. The offices are located at:

Main/Chicago Office
20 N. Michigan, Ste 300
Chicago, Illinois 60602
(800) 537-2632 or
(312) 341-0022
TTY: (800) 610-2779
Fax: (312) 341-0295

Central Illinois
1 West Old Capitol Plaza, Suite 816
Springfield, IL 62701O Box 276
(217) 544-0464
(800) 758-0464
TTY: (800) 610-2779
Fax: (217) 523-0720

Northwestern Illinois
1515 Fifth Avenue, Suite 420
Moline, IL 61265
(309) 786-6868
(800) 758-6869
TTY: (800) 610-2779
Fax: (309) 797-8710

Southern Illinois
300 E. Main Street, Suite 18
Carbondale, IL 62901
(618) 457-7930
(800) 758-0559
TTY: (800) 610-2779
Fax: (618) 457-7985

Website: www.equipforequality.org

I certify that I provided respondent with a copy of this form.

◯ English ◯ Spanish ◯ Other Specify language: _____ on _____

Time: _____

Signature: _____

Title: _____

Printed Name: _____

Ref.: 405 ILCS 5/3-403, 5/3-602, 5/3-607, 5/3-610, 5/3-702, 5/3-813, 5/4-306, 5/4-402, 5/4-403, 5/4-405, 5/4-501, 5/4-611, 5/4-705

Inpatient Certificate

Re: _____

(name)

I personally informed the above-named individual of the purpose of this examination and that he or she did not have to speak to me, and that any statements made might be related in court as to the individual's clinical condition or need for services. Additionally, if this examination was for the purpose of determining that the above-named individual is developmentally disabled and dangerous, I informed the individual of his or her right to speak with a relative, friend or attorney before the examination, and of his or her right to have an attorney appointed for him or her if he or she so desired.

_____

Signature of Examiner

On _____ (date) , _____ (year) , at _____ (time) ◯ a.m. ◯ p.m. , I personally examined the above-named individual. The examination was conducted at _____

(name of location)

Based on the foregoing examination it is my opinion that he or she is:

☐ A person with mental illness who, because of his or her illness is reasonably expected, unless treated on an inpatient basis, to engage in conduct placing such person or another in physical harm or in reasonable expectation of being physically harmed;

☐ A person with mental illness who, because of his or her illness is unable to provide for his or her basic physical needs so as to guard himself or herself from serious harm, without the assistance of family or others, unless treated on an inpatient basis;

☐ A person with mental illness who: refuses treatment or is not adhering adequately to prescribed treatment; because of the nature of his or her illness is unable to understand his or her need for treatment; and if not treated on an inpatient basis, is reasonably expected based on his or her behavioral history, to suffer mental or emotional deterioration and is reasonably expected, after such deterioration, to meet the criteria of either paragraph one or paragraph two above;

☐ An individual who is developmentally disabled and unless treated on an in-patient basis is reasonably expected to inflict serious physical harm upon himself or herself or others in the near future, and/or

☐ Is in need of immediate hospitalization for the prevention of such harm.

I base my opinion on the following (including clinical observations, factual information):

I believe that the individual is subject to (check one):

◯ Involuntary inpatient admission and is not in need of immediate hospitalization

◯ Involuntary inpatient admission and is in need of immediate hospitalization

◯ Judicial inpatient admission and is not in need of immediate hospitalization

◯ Judicial inpatient admission and is in need of immediate hospitalization

Date: _____ Signature: _____

Title: _____ Printed Name: _____

IL 462-2006 (R-8-13) Inpatient Certificate
Printed by Authority of the State of Illinois -0- Copies

Ref.: 405 ILCS 5/3-607, 3-702(b), 3-803, 3-804, 3-906
4-405, 4-502(b), 4-603, 4-604, 4-705(c)

ORDER FOR DETENTION, EXMAINATION, DIAGNOSTIC EVALUATION

State of Illinois

CIRCUIT COURT FOR THE _____ JUDICIAL CIRCUIT

_____ COUNTY

IN THE MATTER OF)

Asserted to be a person)

Subject to _____ Admission
(involuntary/judicial)

This matter coming to be heard on the petition of _____
and the court having been fully advised: (name)

IT HAS BEEN ORDERED THAT:

1. _____ submit to an examination by:
(name)

- ☐ a qualified examiner
- ☐ a clinical psychologist
- ☐ a physician
- ☐ a psychiatrist

at _____ M., on _____ , _____ at _____
(time) (date) (year) (address)

IT IS FURTHER ORDERED THAT. (check appropriate numbers):

2. ☐ The respondent be allowed to remain in his or her place of residence until such time as he or she may be examined.
3. ☐ The clerk issued a writ directing a peace officer to take _____
(name)

to _____ on _____ , _____ , for examination.
(facility) (date) (year)

4. ☐ The clerk issued a writ directing a peace officer to take _____
(name)

and take him or her to _____ on _____ , _____ ,
(facility) (date) (year)

for detention and examination provided herein.

5. ☐ _____ is hereby appointed to examine
(name)

_____ and report to this court by on _____ , _____
(name) (date) (year)

Date: _____ Enter: _____
Judge

IL 462-2008 (R-7-00) (formerly MHDD-8)

Ref.: (505 ILCS 5/3-510, 5/3-811

ORDER FOR TREATMENT OR DISCHARGE

State of Illinois

CIRCUIT COURT FOR THE _____ JUDICIAL CIRCUIT

_____ COUNTY

IN THE MATTER OF) DOCKET NUMBER

)

)

_____) _____

This matter coming to be heard on the petition of _____

(print name of petitioner)

and the court being fully advised:

IT IS HEREBY ORDERED THAT _____

(print name)

- ☐ Petition is dismissed
- ☐ Is a person subject to involuntary admission
- ☐ Is not a person subject to involuntary admission
- ☐ Is a minor who should be hospitalized

IT IS FURTHER ORDERED THAT he/she shall be:

- ☐ discharged
- ☐ hospitalized in a Department of Human Services mental health or developmental center, which is the least restrictive environment currently appropriate and available
- ☐ undergo a program of alternative treatment
- ☐ hospitalized in _____, a licensed private hospital
- ☐ hospitalized with the Veterans Administration
- ☐ treated at _____, a private or community mental health facility
- ☐ be placed in the care and custody of _____, and the custodian shall have the following authority and no other:
- ☐ continued in treatment in accordance with the original order
- ☐ taken into custody by a peace officer and transported to _____
- ☐ other, please specify

THIS ORDER REMAINS IN EFFECT FOR _____ DAYS.

(a period not to exceed 90 days)

Date: _____ Entered: _____

(Judge)

NOTICE TO PERSONS RECEIVING THIS ORDER

IF YOU ARE AFFECTED BY OR INTERESTED IN THIS COURT ORDER, YOU SHOULD KNOW THAT:

1. **A FINAL ORDER OF COURT MAY BE APPEALED.**
The court must notify the respondent of the right to appeal and of indigent's right to free transcripts and counsel. If the individual wishes to appeal and cannot obtain counsel, counsel should be appointed pursuant to Sections 3-818 or 4-605 of the Mental Health and Developmental Disabilities Code.

2. **AN ORDER FOR ADMISSION IS INITIALLY VALID FOR NO MORE THAN 90 DAYS. A SUBSEQUENT ORDER MAY BE ENTERED FOR AN ADDITIONAL PERIOD OF 90 DAYS. Thereafter an order may be valid for up to 180 days. If the facility director does not discharge the individual during that period or petition for continued hospitalization, the individual must be released.**

3. **RELATIVES OR FRIENDS MAY TRANSPORT A PERSON ADMITTED BY ORDER.**
The court may authorize a relative or friend of the person to transport him/her to the appropriate facility if such person can do so safely and humanely.

4. **UNWILLINGNESS OR INABILITY OF THE INDIVIDUAL'S PARENT, GUARDIAN, OR PERSON IN LOCAL PARENTIS TO PROVIDE FOR HIS/HER CARE OR RESIDENCE IS NOT GROUNDS FOR THE COURT'S REFUSING TO ORDER DISCHARGE.**
A petition may be filed under the Juvenile Court Act or Probate Act to ensure appropriate care and residence.

5. **THE COURT MAY MODIFY THIS ORDER IN THE FUTURE.**
If the individual's treatment needs change, or if the facility or progam cannot meet the individual's needs, upon petition or other proper method of review the court may modify this order and enter a fresh one based on the new circumstances.

AT A MINIMUM, THESE PERSONS SHOULD RECEIVE THIS ORDER:

(a) the respondent;
(b) his or her attorney; and
(c) the facility director of the facility or program.

Ref. 405 ILCS 5/3-403, 3-509, 3-811,
3-901, 4-306, 4-407, 4-502(c), 4-505

ORDER FOR HEARING

STATE OF ILLINOIS

CIRCUIT COURT FOR THE _____ **JUDICIAL COURT**

_____ **COUNTY**

IN THE MATTER OF)

)

Asserted to be a Person

Subject to _____ Admission
(involuntary/judicial)

This cause coming to be heard on _____
(state specific basis for the hearing)

and the court being fully advised:

IT IS ORDERED THAT:

☐ 1. a hearing on the matter is set for _____ (date), _____ (year), at _____ (time) M.

at _____ (Location or Address) in _____ (city), Ilinois;

☐ 2. notice of the time and place of hearing shall be sent by the Clerk of the Court to all required and appropriate persons; or

☐ 3. a writ be issued directing the sheriff to take custody of _____ (name)

and bring him or her before this court at the time and place set for hearing.

Date: _____ ENTER:

_____
Judge

ORDER FOR HEARING

Ref.:405 ILCS 5/2-107.1

PETITION FOR ADMINISTRATION OF PSYCHOTROPIC MEDICATIONS / ELECTROCONVULSIVE THERAPY

STATE OF ILLINOIS

CIRCUIT COURT FOR THE _____ JUDICIAL DISTRICT

_____ COUNTY

IN THE MATTER OF) DOCKET NUMBER
)
)
_____) _____

Who is alleged to be a person who has ☐ Mental Illness ☐ Developmental Disability (Check One or Both) and for whom this petition for

administration of psychotropic medication and/or electro convulsive therapy is initiated for the following reasons (briefly explain reasons individual meets the criteria for each of the following):

_____

1. ☐ The individual lacks capacity to give informed consent to:

☐ psychotropic medication ☐ electroconvulsive therapy

and, (Check One or Both)

2. That because of said mental illness or developmental disability, the individual exhibits any one of the following: deterioration of ability to function, suffering or threatening behavior; and

3. That the illness or disability has existed for a period marked by the continuing presence of the symptoms set forth item (2) above, or the repeated episodic occurrence of these symptoms; and

4. That the benefits of the treatment clearly outweigh the harm; and

5. That the individual lacks the capacity to make a reasoned decision about the treatment; and

6. That other less restrictive services were explored and found inappropriate; and

7. The petition seeks authorization for testing and other procedures, that said testing and procedures are essential for the safe and effective administration of treatment.

8. The petitioner has made a good faith attempt to determine whether the individual has executed a Power of Attorney for Health Care Law or a declaration for mental health treatment under the Mental Health Treatment Preference Declaration Act. If either of the above are available, they are attached to the Petition.

WHEREFORE, the Petitioner request the court for an order authorizing the clinical staff member

_____ at the _____ facility/hospital to administer one or
(psychiatrist's name) (name of institution)

more of the following listed treatment(s) to the individual _____ .
(individual's name)

PSYCHOTROPIC MEDICATION

To administer psychotropic medication to the individual for _____ days (not to exceed 90).

Psychotropic medication to be given to individual:

First Choice: _____ _____

Name of Medication | Dosage Range

Alternatives: _____ _____

Name of Medication | Dosage Range

_____ _____

Name of Medication | Dosage Range

_____ _____

Name of Medication | Dosage Range

ELECTRO CONVULSIVE THERAPY

To administer electro convulsive therapy to the individual for _____ days (not to exceed 90).

The initial number of treatments to be administered will be _____ treatments.

number

Additionally, the following _____ electro convulsive maintenance treatments will be given to the individual with the timeframe specified.

TESTING AND/OR OTHER PROCEDURES (if applicable)

Specific testing and procedure necessary to administer the above are as follows:

I have read and understood this Petition and affirm that the statements made by me are true to the best of my knowledge. I affirm that I advised the individual, in writing, of the risks and benefits of the proposed treatment.

Dated: _____ Signed: _____

Address:

Realtionship to Respondent: _____

Ref.: 405 ILCS 5/2-107.1

ORDER FOR ADMINISTRATION OF PSYCHOTROPIC MEDICATIONS / ELECTROCONVULSIVE THERAPY

STATE OF ILLINOIS

CIRCUIT COURT FOR THE _____ JUDICIAL COURT

COUNTY _____

In the matter of)

)

)

) DOCKET NUMBER _____

This matter coming to be heard on the petition of _____ (name of petitioner)

and the court **having found that:**

1) The individual has a (check either one or both) ☐ **serious mental illness** ☐ **developmental disability** and,

2) The individual exhibits any one of the following: a) deterioration of his or her ability to function, b) suffering; or c) threatening behavior;

3) The illness or disability has existed for a period marked by the continuing presence of the symptoms set forth in item (2) above, or the repeated episodic occurrence of these symptoms;

4) The benefits of the treatment will outweigh the harm;

5) The individual lacks the capacity to make a reasoned decision about the treatment;

6) Other less restrictive services were explored and found inappropriate;

7) Testing and/or other procedures are essential for the safe and effective administration of treatment and;

8) A good faith attempt was made to determine whether the individual has executed a Power of Attorney for Health Care or a declaration for mental health treatment.

IT IS HEREBY ORDERED THAT THE PETITION IS GRANTED.

_____ has been authorized to receive ☐ Psychotropic Medication and/or ☐ Electroconvulsive Therapy

(Individual's Name)

The treatment will be administered by _____ at _____.

(Physician) (Facility Name)

Reset Form

PSYCHOTROPIC MEDICATION

To administer psychotropic medication to the individual for _____ days (not to exceed 90/180* days)

Psychotropic medications to be given to the individual.

1st Choice _____ _____
Name of Medication — Dosage Range

Alternatives _____ _____
Name of Medication — Dosage Range

_____ _____
Name of Medication — Dosage Range

_____ _____
Name of Medication — Dosage Range

ELECTROCONVULSIVE THERAPY

To administer electroconvulsive therapy to the indivdual for _____ days (not to exceed 90/180* days)

The initial number of treatments to be administered will be _____ treatments.
number

Additionally, the following _____ electroconvulsive therapy maintenance treatment will be given to the individual within.
number

the timeframe specified.

TESTING AND/OR OTHER PROCEDURES (if applicable)

Specific testing and procedures necessary to administer the above are as follows:

Dated: _____

Entered:

_____
JUDGE

* In no event shall an order issued under this Section be effective for more than 90 days. A second 90 day period may be authorized pursuant to a hearing that complies with the standards and procedures of Section 2-107.1 (A-5). Thereafter, additional 180 day periods of psychotropic medication and/or electroconvulsive therapy may be ordered.

PETITION FOR INVOLUNTARY OUTPATIENT ADMISSION

STATE OF ILLINOIS

CIRCUIT COURT FOR THE _____ JUDICIAL CIRCUIT

_____ COUNTY

IN THE MATTER OF

)
)
)
)
)
)

Docket No. _____

_____

(Name of Respondent)

Who is asserted to be a person subject to involuntary outpatient admission and for whom this petition is being initiated by reason of: (select one)

☐ Admission on an outpatient basis by court order; (405 ILCS 5/3-750).

☐ Respondent submitted written notice of desire to be discharged; (405 ILCS 5/3-403).

☐ Respondent failed to reaffirm a desire to continue treatment; (405 ILCS 5/3-404).

☐ Respondent continues to be subject to involuntary admission; (405 ILCS 5/3-813).

I assert that _____

☐ A person who would meet the criteria for admission on an inpatient basis as specified in Section 1-119* in the absence of treatment on an outpatient basis and for whom treatment on an outpatient basis can only be reasonably ensured by a court order mandating such treatment; or

☐ A person with a mental illness which, if left untreated, is reasonably expected to result in an increase in the symptoms caused by the illness to the point that the person would meet the criteria for commitment under Section 1-119*, and whose mental illness has, on more than one occasion in the past, caused that person to refuse needed and appropriate mental health services in the community.

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*1-119 (1): A person with mental illness who because of his or her illness is reasonably expected, unless treated on an inpatient basis, to engage in conduct placing such person or another in physical harm or in reasonable expectation of being physically harmed; or

(2): A person with mental illness who because of his or her illness is unable to provide for his or her basic physical needs so as to guard himself or herself from serious harm without the assistance of family or others, unless treated on an inpatient basis; or

(3): A person with mental illness who:

(i) refuses treatment or is not adhering adequately to prescribed treatment;

(ii) because of the nature of his or her illness, is unable to understand his or her need for treatment; and

(iii) if not treated on an inpatient basis, is reasonably expected, based on his or her behavioral history, to suffer mental or emotion deterioration and is reasonably expected, after such deterioration, to meet the criteria of either paragraph (1) or paragraph (2) of this section.

I base the foregoing assertion on the following (provide a detailed statement including a description of the signs and symptoms of a mental illness and of any acts, threats, or other behavior or pattern of behavior supporting the assertion and the time and place of their occurrence). **ADDITIONAL PAGE(s) ATTACHED AS NECESSARY:**

Below is a list of all witnesses by whom the facts asserted may be proven (include addresses and phone numbers):

Listed below are the names and addresses of the spouse, parent, guardian, or substitute decision maker, if any, and close relative or, if none, a friend of the respondent whom I have reason to believe may know or have any of the other names and addresses. If names and addresses are not listed below, I made a diligent inquiry to identify and locate these individuals and the following describes the specific steps taken by me in making this inquiry (additional page(s) may be attached as necessary):

○ I do ○ I do not have a legal interest in this matter.

○ I do ○ I do not have a financial interest in this matter.

○ I am ○ I am not involved in litigation with the respondent.

☐ Although I have indicated that I have a legal or financial interest in this matter or that I am involved in litigation with the respondent, I believe it would not be practicable or possible for someone else to be the petitioner for the following reasons:

☐ No certificate is attached.

☐ One certificate is attached.

☐ Two certificates are attached.

* Each certificate must be completed within 72 hours of examination of respondent.

** At least one certificate must be completed by a psychiatrist.

The petitioner can request to be notified if the facility director approves the respondent's request for voluntary or informal admission prior to adjudication. The petitioner may also request to be notified of the respondent's discharge under section 3-902 (d) of the Mental Health and Developmental Disabilities Code. Failure to indicate a choice will be treated as a decision NOT to be notified.

☐ If respondent requests and is approved for voluntary or informal admission prior to adjudication, I wish to be notified using the contact information supplied below. (Hospital staff use form IL462-2203 for notification purposes).

☐ If respondent is discharged, I wish to be notified using the contact information supplied below. (Hospital staff use form IL462-2208M for notification purposes).

☐ I do not wish to be notified in either of the two situations described above.

The petitioner has made a good faith attempt to determine whether the recipient has executed a power of attorney for health care under the Power of Attorney for Health Care Law or a declaration for mental health treatment under the Mental Health Treatment Preference Declaration Act and to obtain copies of these instruments if they exist.

I have read and understood this petition and affirm that the statements made by me are true to the best of my knowledge. I further understand that knowingly making a false statement on this Petition is a Class A Misdemeanor.

Date: _____ Signed: _____

Relationship to Respondent: _____

Printed Name: _____

Address:

Telephone Number: _____

Within 12 hours of admission to the facility under this status, I gave the respondent a copy of this Petition (MHDD-5). I have explained the Rights of Admittee to the respondent and have provided him or her with a copy of it. I have also provided him or her with a copy of Rights of Individuals Receiving Mental Health and Developmental Services (MHDD-1) and explained those rights to him or her (405 ILCS 5/3-609).

Date/Time of Admission: _____ Signed: _____

To Mental Health Facility/Psychiatric Unit

Printed Name: _____

Title: _____

RIGHTS OF ADMITTEE

1. If you have been brought to this facility on the basis of this petition alone, you will not be immediately admitted, but will be detained for examination. You must be examined by a qualified professional within 24 hours or be released.

2. When you are first examined by a physician, clinical psychologist, qualified examiner, or psychiatrist, you do not have to talk to the examiner. Anything you say may be related by the examiner in court on the issue of whether you are subject to involuntary or judicial admission.

3. At the time that you have been certified, and a copy of the petition and certificate will be filed with the court and you may be admitted to the facility. A copy of the petition shall also be given to you.

4A. If you are alleged to be subject to involuntary admission (mentally ill) you must also be examined within 24 hours excluding Saturdays, Sundays, and holidays by a psychiatrist (different from the first examiner) or be released. If you are alleged to be subject to involuntary admission the court will set the matter for a hearing.

4B. If you are alleged to be subject to judicial admission (developmentally disabled) the court will set a hearing upon receipt of the diagnostic evaluation which is required to be completed within 7 days.

5A. If you are alleged to be subject to involuntary admission (mentally ill) and if the facility director approves, you may be admitted to the facility as a voluntary admittee upon your request any time prior to the court hearing. The court may require proof that voluntary admission is in your best interest and in the public interest.

5B. If you are alleged to be subject to judicial admission (developmentally disabled) and if the facility director approves, you may decide that you prefer to admit yourself to the facility rather than have the court decide whether you ought to be admitted. You may make the request for administrative admission at any time prior to the hearing. The court may require proof that administrative admission is in your best interest and the public interest.

6. You have the right to request a jury.

7. You have the right to request an examination by an independent physician, psychiatrist, clinical psychologist, or qualified examiner of your choice. If you are unable to obtain an examination, the court may appoint an examiner for you upon your request.

8. You have the right to be represented by an attorney. If you do not have funds or are unable to obtain an attorney, the court will appoint an attorney for you.

9. You have the right to be present at your court hearing.

10. As a general rule, you do not lose any of your legal rights, benefits, or privileges simply because you have been admitted to a mental health facility (see your copy of the "Rights of Individuals"). However, you should know that persons admitted to mental health facilities will be disqualified from obtaining Firearm Owner's Identification Cards, or may lose such cards obtained prior to admission.

11. Information about the health care services you receive at a mental health or developmental disabilities facility is protected by privacy regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (P.O. 104-191) at 45 CFR 160 and 164. Your personally identifiable health information will only be used and/or released in accordance with HIPAA and the Illinois Mental Health and Developmental Disabilities Confidentiality Act [740 ILCS 110].

A Guardianship and Advocacy Commission is a state agency consisting of three divisions: Legal Advocacy Services, Human Rights Authority and the Office of the State Guardian. The Commission is located at the following addresses:

East Central Regional Office
2125 S. First Street
Champaign, IL 61820
Phone: (217) 278-5577
Fax: (217) 278-5588

Peoria Regional Office
401 N. Main Street, Suite 620
Peoria, IL 61602
Phone: (309) 671-3030
Fax: (309) 671-3060

Rockford Regional Office
4302 N. Main Street, Suite 108
Rockford, IL 61103
Phone: (815) 987-7657
Fax: (815) 987-7227

Egyptian Regional Office
47 Cottage Drive
Anna, Illinois 62906-1669
Phone: (618) 833-4897
Fax: (618) 833-5219

West Suburban Regional Office
Madden Mental Health Center
1200 S. First Street, P.O. Box 7009
Hines, IL 60141
Phone: (708) 338-7500
Fax: (708) 338-7505

Metro East Regional Office
Holly Bldg., 4500 College
Suite 100
Alton, IL 62002
Phone: (618) 474-5503
Fax: (618) 474-5517

North Suburban Regional Office
9511 Harrison Avenue
Des Plaines, Illinois 60016
Phone: (847) 294-4264
Fax: (847) 294-4263

Chicago Regional Office
160 N. La Salle Street
Suite S500
Chicago, IL 60601
Phone: (312) 793-5900
Fax: (312) 793-4311

Springfield Regional Office
521 Stratton Building
401 S. Spring Street
Springfield, IL 62706
Phone: (217) 785-1540
Fax: (217) 524-0088

Equip for Equality, Inc. is an independent, not-for-profit organization that administers the federal protection and advocacy system to people with disabilities in Illinois. Equip for Equality, Inc., provides self-advocacy assistance, legal services, education, public policy advocacy, and abuse investigations. The offices are located at:

Main/Chicago Office
20 N. Michigan, Ste 300
Chicago, Illinois 60602
(800) 537-2632 or
(312) 341-0022
TTY: (800) 610-2779
Fax: (312) 341-0295

Central Illinois
1 West Old Capitol Plaza, Suite 816
Springfield, IL 62701O Box 276
(217) 544-0464
(800) 758-0464
TTY: (800) 610-2779
Fax: (217) 523-0720

Northwestern Illinois
1515 Fifth Avenue, Suite 420
Moline, IL 61265
(309) 786-6868
(800) 758-6869
TTY: (800) 610-2779
Fax: (309) 797-8710

Southern Illinois
300 E. Main Street, Suite 18
Carbondale, IL 62901
(618) 457-7930
(800) 758-0559
TTY: (800) 610-2779
Fax: (618) 457-7985

Website: www.equipforequality.org

I certify that I provided respondent with a copy of this form.

◯ English ◯ Spanish ◯ Other Specify language: _____ on _____

Time: _____

Signature: _____

Title: _____

Printed Name: _____

Ref.: 405 ILCS 5/3-403, 5/3-602, 5/3-607, 5/3-610, 5/3-702, 5/3-813, 5/4-306, 5/4-402, 5/4-403, 5/4-405, 5/4-501, 5/4-611, 5/4-705

OUT-PATIENT CERTIFICATE

Re: _____

(name)

I personally informed the above-named individual of the purpose of this examination and that he or she did not have to speak to me, and that any statements made might be related in court as to the individual's clinical condition or need for services. Additionally, if this examination was for the purpose of determining that the above-named individual is mentally retarded and dangerous, I informed the individual of his or her right to speak with a relative, friend or attorney before the examination, and of his or her right to have an attorney appointed for him or her if he or she so desired.

_____

Signature of Examiner

On _____, _____, at _____ ☐ a.m. ☐ p.m., I personally examined the

(date) (year) (time)

above-named individual. The examination was conducted at _____

(name of location)

Based on the foregoing examination it is my opinion that he or she is:

☐ A person who would meet the criteria for admission on an inpatient basis as specified in Section 1-119* in the absence of treatment on an outpatient basis and for whom treatment on an outptient basis can only be reasonably ensured by a court order mandating such treatment; or;

☐ A person with mental illness which, if left untreated, is reasonably expected to result in an increase in the symptoms caused by the illness to the point that the person would meet the criteria for commitment under Section 1-119*, and whose mental illness has, on more than one occasion in the past, caused that person to refuse needed and appropriate mental health services in the community.

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*-119: (1) A person with mental illness who because of his or her illness is reasonably expected, unless teated on an inpatient basis, to engage in conduct placing such person or another in physical harm or in reasonable expectation of being physically harmed; or
(2) A person with mental illness who because of his or her illness is unable to provide for his or her basic physical needs so as to guard himself or herself from serious harm without the assistance of family or others, unless treated on an inpatient basis; or
(3) A person with mental illness who:
(i) refuses treatment or is not adhering adquately to prescribed treatment;
(ii) because of the nature of his or her illness, is unable to understand his or her need for treatment; and
(iii) if not treated on an inpatient basis, is reasonably expected, based on his or her behavioral history, to suffer mental or emotional deterioration and is reasonably expected, after such deterioration, to meet the criteria of either paragraph (1) or paragraph (2) of this section.

I base my opinion on the following (include clinical observations, factual information):

I believe that the individual is subject to (check one):
◯ involuntary outpatient admission and is in need of immediate hospitalization
◯ involuntary outpatient admission and is not in need of immediate hospitalization

Date: _____ Signature: _____

Title: _____ Printed Name: _____

(check one) ☐ Psychiatrist ☐ Physician ☐ Qualified Examiner ☐ Clinical Psychologist