Department of Corrections
WASHINGTON STATE

REQUEST FOR CONTINUANCE OF INVOLUNTARY ANTIPSYCHOTIC HEARING

PATIENT NAME	DOC NUMBER

Emergency involuntary antipsychotics started: ☐ No ☐ Yes – Date started: _____

Date hearing scheduled: _____

Current hearing date: _____

Continuance requested by: _____ _____
CHAIRPERSON DATE

A continuance (for up to 7 days) for the Involuntary Antipsychotic Hearing of the above named patient is requested for the following reason(s):

Please document the steps taken to avoid the necessity of this continuance:

☐ APPROVED ☐ DISAPPROVED

_____ _____
DIRECTOR OF MENTAL HEALTH/DESIGNEE PRINTED NAME AND SIGNATURE DATE

Comments:

State law and/or federal regulations prohibit disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.