Department of Corrections
WASHINGTON STATE

NOTICE OF INVOLUNTARY ANTIPSYCHOTIC HEARING (24 HOUR)

PATIENT NAME	DOC NUMBER

HEARING DATE	HEARING TIME

CURRENT DIAGNOSIS _____

BASIS FOR REFERRAL _____

YOU HAVE THE FOLLOWING RIGHTS:

1. An advisor will be appointed for you and will help you at your hearing if you wish. The advisor will represent your interests if you do not attend the hearing. The advisor will act solely as your advocate. This individual may be an employee/contractor of the Department of Corrections. The advisor will be knowledgeable about the hearing process and have knowledge about mental health issues. Your advisor will meet with you at least 24 hours prior to the hearing.
2. You have the right to discontinue involuntary medications 24 hours before the hearing and until the hearing adjourns.
3. You have a right to refuse to participate in the hearing process.
4. You have the right to be present at the hearing, to be heard in person at the hearing, and to present documentary evidence on your behalf.
5. You have a right to present relevant testimony yourself or through witnesses that you may request through your advisor. You also have a right to question your own witnesses and witnesses for the institution.
6. You have the right to be informed of the evidence relied upon for the proposed involuntary treatment.
7. You may remain silent at the hearing.

RIGHTS READ BY:

PRINTED NAME	SIGNATURE	DATE	TIME

I would like the following witness(es) to appear on my behalf:

_____

_____

I have received a copy of this Notice of Hearing and have been advised of my rights.

PATIENT SIGNATURE	DATE	TIME

SERVING PARTY SIGNATURE	DATE	TIME

WITNESS SIGNATURE (IF PATIENT REFUSES TO SIGN)	DATE	TIME

Distribution: **Original** – Health Record **Copy** – Patient

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.