Department of Corrections
WASHINGTON STATE

☐ 14-DAY ☐ 180-DAY
INVOLUNTARY ANTIPSYCHOTIC HEARING MINUTES STATEMENT

PATIENT NAME (Last, First)		DOC #
FACILITY/UNIT	HEARING DATE	HEARING TIME

STATEMENT

Personal opinion whether involuntary antipsychotics should/should not be authorized and statement about the relationship or lack of relationship between mental illness and dangerousness and/or grave disability or that such would recur if not authorized.

SIGNATURE (AND CREDENTIALS) OF: DATE

☐ COMMITTEE CHAIRPERSON
☐ NON-TREATING PSYCHIATRIST
☐ NON-TREATING PSYCHOLOGIST

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.