PHYSICIAN NAME: FACILITY: ADDRESS: CITY: ZIP: TELEPHONE NO.:	*FOR COURT USE ONLY* To keep other people from seeing what you entered on your form, please press the Clear This Form button at the end of the form when finished.
SUPERIOR COURT OF CALIFORNIA, COUNTY OF SAN DIEGO CENTRAL DIVISION, FAMILY COURT, 1555 6TH AVE., SAN DIEGO, CA 92101	
IN THE MATTER OF	
PATIENT AT	
PETITION OF TREATING PHYSICIAN REGARDING CAPACITY TO CONSENT TO OR REFUSE ANTIPSYCHOTIC MEDICATION	D.O.B.

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 involuntarily detained in a mental health facility pursuant to Welf. & Inst. Code § 5000 et seq. The patient ☐ is ☐ is not involuntarily detained on a 30-day hold pursuant to Welf. & Inst. Code §§ 5270.10-5270.65.
3. The patient is presently showing symptoms of a mental disorder known as _____

   _____
4. The symptoms of this diagnosis that the patient is currently experiencing are _____

   _____

   _____

   _____

   _____

   _____
5. In my professional opinion, the patient would benefit from the administration of the following antipsychotic medications (as broadly defined by Welf. & Inst. Code § 5008(l)): _____

   _____
6. Due to the symptoms of the mental disorder identified above, the patient does not have the capacity to give informed consent to treatment by antipsychotic medications.
7. Pursuant to Welf. & Inst. Code § 5332 I request that a capacity hearing be held for a legal determination as to whether the patient has the capacity to give or withhold informed consent for treatment by antipsychotic medications (as broadly defined by Welf. & Inst. Code § 5008(l)).

IN THE MATTER OF	PETITION NUMBER

8. I, or another treating physician, will be present for the hearing and will be prepared to testify regarding questions and answers set forth in a Treating Physician's Declaration Regarding Capacity of Patient to Consent to or Refuse Antipsychotic Medication (SDSC Form #MHC-055) If I am unable to testify, and if there is no other treating physician testifying, the *Treating Physician's Declaration* will be forwarded to the Office of the Counselor in Mental Health on a date in advance of the hearing, and a qualified witness will then represent me and be prepared to respond to related questions, and give additional information regarding the capacity of the patient to give or withhold informed consent to medication.
9. I understand that a treating physician must be present for the hearing or a Treating Physician's Declaration Regarding Capacity of Patient to Consent to or Refuse Antipsychotic Medication (SDSC Form #MHC-055) must be filed prior to the date of the hearing, and that without these requirements being met a hearing will not be held.

WHEREFORE, I request:

1. A representative, such as a public defender or a patient rights advocate, be appointed for the patient;
2. A court appointed Mental Health Hearing Officer conduct a hearing for the purpose of determining the patient's capacity to consent to or refuse antipsychotic medication;
3. A hearing be conducted within 48 hours from the time of filing this petition (excluding Saturdays, Sundays, and court holidays).

Date: _____ _____

Treating Physician

VERIFICATION

I, the undersigned, state that I am the declarant and treating physician in the above entitled matter. I have read the foregoing **Petition of Treating Physician Regarding Capacity to Consent to or Refuse Antipsychotic Medication** and know its contents, and the same is true of my personal knowledge, except as to matters which are stated upon my information and belief, and as to those matters, I believe them to be true.

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

Executed this _____ of _____ at _____, California.

_____

Signature of Treating Physician

_____

Printed Name of Treating Physician