Physician Opinion for Involuntary Medication

Date: _____

I have examined:

Name: _____ GDC ID #: _____

And find the above-named offender to be:

_____

I (do) (do not) recommend the need for involuntary medication.

The reason(s) I have for this decision is (are) as follows:

_____

_____

_____

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_____

_____

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_____

_____/_____
Signature/Title Date

Printed Name _____

Form no. M66-01-02

Retention Schedule: Completed forms shall be placed in the medical file (original – section 5). A copy shall be given to the offender and placed in the offender's mental health file (section 5). At the end of the offender's need for mental health services and/or sentence, the mental health file shall be placed within the offender's health record and retained for 10 years.