Notification of Involuntary Medication Committee Decision

Date: _____

To: _____ _____
Offender Name ID #

From: _____ _____
Mental Health Unit Manager Facility

RE: Decision of Mental Health Involuntary Medication Due Process

This is to advise you that the Mental Health Involuntary Due Process Committee met on _____ at _____ hours and made the following finding:
(date) (time)

[ ] You met criteria for involuntary medication administration. The medication will continue to be administered involuntarily until your physician determines that it is no longer necessary. This decision may be reviewed through a rehearing in six (6) months.

[ ] You did not meet criteria for involuntary medication administration. The involuntary administration of the medication will be discontinued. Your physician may continue to offer medication to you on a voluntary basis.

Cc: _____
(Offender Advocate)

Form No. M66-01-07

Retention Schedule: Completed forms shall be given to the offender (original), a copy shall be placed in the offender's mental health file (section 5), given to the offender Advocate, and placed in the medical 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.