PHYSICIAN NAME: FACILITY: ADDRESS: CITY: ZIP: TELEPHONE NO.:	*FOR COURT USE ONLY*
SUPERIOR COURT OF CALIFORNIA, COUNTY OF SAN DIEGO CENTRAL DIVISION, CENTRAL COURTHOUSE, 1100 UNION ST., 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 section 5000 et seq. The patient ☐ is ☐ is not involuntarily detained on a 30-day hold pursuant to Welf. & Inst. Code sections 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 ________________________________
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____
____
____
____
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)).

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).
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.

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Signature of Treating Physician

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Printed Name of Treating Physician