State of Illinois
Department of Human Services

NOTICE OF TREATMENT PANEL MEETING FOR MEDICATION REVIEW

As part of planning the treatment and care for _____, we
name of individual

would like to invite you to participate in a meeting to discuss medication for

_____.
name of individual

The meeting will be held on _____, at _____
day of week and day — time including a.m. or p.m.

in _____ of _____
room and building — agency name, street address and city

While we encourage you to participate in person, you may also participate by telephone, or you can have someone attend with you or in your place. If you have any questions or wish to let us know whether you will be attending the meeting, please contact

_____ at _____
name of staff person and title — telephone number and extension

Individual _____

Date of Birth: _____ Sex: _____

Identification Number: _____

Facility: _____

Subunit: _____

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NOTICE OF TREATMENT PANEL MEETING FOR MEDICATION REVIEW

I certify that on _____ I, _____ ,

DATE (must be at least 7 days prior to meeting date) name of staff person

☐ delivered in person this NOTICE to the individual receiving medication.

☐ placed a copy of the NOTICE in the individual's cllinical record, and

☐ mailed a copy of this NOTICE to each of the following entitled to receive notice UNLESS

☐ individual wished no one to be notified.

EXCEPTION: Guardian of person must be notified regardless of individual's wishes.

☐ Guardian of Person

Name _____

Street Address _____

City/State/Zip _____

☐ DesignatedPerson

(Individual must sign authorization for release if he or she wishes someone other than the Guardian to represent him or her)

Name _____

Street Address _____

City/State/Zip _____

☐ Representative of Guardianship and Advocacy Commission

Name _____

Street Address _____

City/State/Zip _____

_____ _____ _____

Signature of Staff Person Title Date/Time

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