Ref.:405 ILCS 5/2-107.1

PETITION FOR ADMINISTRATION OF PSYCHOTROPIC MEDICATIONS / ELECTROCONVULSIVE THERAPY

STATE OF ILLINOIS

CIRCUIT COURT FOR THE _____ JUDICIAL DISTRICT

_____ COUNTY

IN THE MATTER OF) DOCKET NUMBER
)
)
_____) _____

Who is alleged to be a person who has ☐ Mental Illness ☐ Developmental Disability (Check One or Both) and for whom this petition for

administration of psychotropic medication and/or electro convulsive therapy is initiated for the following reasons (briefly explain reasons individual meets the criteria for each of the following):

_____

1. ☐ The individual lacks capacity to give informed consent to:

☐ psychotropic medication ☐ electroconvulsive therapy

and, (Check One or Both)

2. That because of said mental illness or developmental disability, the individual exhibits any one of the following: deterioration of ability to function, suffering or threatening behavior; and

3. That the illness or disability has existed for a period marked by the continuing presence of the symptoms set forth item (2) above, or the repeated episodic occurrence of these symptoms; and

4. That the benefits of the treatment clearly outweigh the harm; and

5. That the individual lacks the capacity to make a reasoned decision about the treatment; and

6. That other less restrictive services were explored and found inappropriate; and

7. The petition seeks authorization for testing and other procedures, that said testing and procedures are essential for the safe and effective administration of treatment.

8. The petitioner has made a good faith attempt to determine whether the individual has executed a Power of Attorney for Health Care Law or a declaration for mental health treatment under the Mental Health Treatment Preference Declaration Act. If either of the above are available, they are attached to the Petition.

WHEREFORE, the Petitioner request the court for an order authorizing the clinical staff member

_____ at the _____ facility/hospital to administer one or
(psychiatrist's name) (name of institution)

more of the following listed treatment(s) to the individual _____ .
(individual's name)

PSYCHOTROPIC MEDICATION

To administer psychotropic medication to the individual for _____ days (not to exceed 90).

Psychotropic medication to be given to individual:

First Choice: _____ _____

Name of Medication | Dosage Range

Alternatives: _____ _____

Name of Medication | Dosage Range

_____ _____

Name of Medication | Dosage Range

_____ _____

Name of Medication | Dosage Range

ELECTRO CONVULSIVE THERAPY

To administer electro convulsive therapy to the individual for _____ days (not to exceed 90).

The initial number of treatments to be administered will be _____ treatments.

number

Additionally, the following _____ electro convulsive maintenance treatments will be given to the individual with the timeframe specified.

TESTING AND/OR OTHER PROCEDURES (if applicable)

Specific testing and procedure necessary to administer the above are as follows:

I have read and understood this Petition and affirm that the statements made by me are true to the best of my knowledge. I affirm that I advised the individual, in writing, of the risks and benefits of the proposed treatment.

Dated: _____ Signed: _____

Address:

Realtionship to Respondent: _____

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