CAUSE NO. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

THE STATE OF TEXAS § IN THE COUNTY COURT

FOR THE BEST INTEREST §

AND PROTECTION OF § AT LAW NUMBER FOUR OF

 §

      (Initials Only), §

THE PROPOSED PATIENT § WILLIAMSON COUNTY, TEXAS

#  GENERAL INFORMATION

1. Applicant's name, address, ***telephone, and cell number***:

2. Proposed Patient's Unit: (if applicable)

3. Relationship, if any, to patient:

4. Proposed Patient's sex:

5. Proposed Patient's age and date of birth:

6. Proposed Patient's race/ethnicity: [ ]  Caucasian [ ]  Black [ ]  Hispanic

  [ ]  Asian [ ]  Other

7. Proposed Patient’s Social Security Number:

8. Proposed Patient’s Driver’s License Number:

9. If the Proposed Patient is a minor or the subject of a guardianship, the parent(s), managing conservator, or guardian, and their address for service:

10. Person(s) or estate, and their address(es), responsible for costs and expenses: (County other than Williamson guaranteeing costs; INDIVIDUAL'S NAME, COURT REPRESENTED, TELEPHONE NUMBER, AND WHEN CONTACTED):

11. Physician/Psychiatrist, if any, treating Proposed Patient:

12. Prior psychiatric/chemical dependency history:

13.. The Proposed Patient has the following pending criminal charges:

14. Current ***temporary*** expiration date:

15. How Proposed Patient entered hospital/facility:

 [ ]  Emergency without warrant (attach copy of law enforcement officer’s NED)

 [ ]  Emergency with warrant (attach copy of court order)

 [ ]  Voluntary (check one below)

 [ ]  Written request for release (attach copy)

 [ ]  Absent without authorization (attach letter from treating physician)

 [ ]  Unable to consent to treatment (attach supporting documents)

 [ ]  Refuses to consent to treat (Dr. must complete #10 on Physician's Certificate)

16. Date, time and circumstances of emergency detention:

17. Acts leading to application:

18. Witnesses' names, addresses, and phone numbers:

19. The name and address for the mental health facility or chemical dependency treatment facility the Proposed Patient is going to - if private facility, consent must be obtained from facility (attach letter confirming consent):

20. Person or agency who is to transport the Proposed Patient:

 SIGNED AND Dated this       day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 2022.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Applicant