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