Partners in Recovery

Special Treatment Plan
Referral for Involuntary Administration of Medications

Consumer Name:_____ ID #_____

Case Manager: _____ Clinic:_____

Psychiatrist/BHMP:_____ Phone:_____

1. How will the consumer's condition be expected to improve through the use of involuntary medications?

_____

_____

2. What medications are recommended for involuntary administration? List medications and dosage:

_____

_____

_____

_____

3. Has the consumer ever received the medications recommended in question #2 before?

_____

_____

4. Does the consumer have any known allergies? Please describe:

_____

_____

_____

_____

5. If side effect medications may be administered, please indicate the following:

☐ Cogentin or Benadryl to be involuntarily administered to the consumer if the consumer refuses oral administration.

_____ _____ _____

Physician requesting involuntary medications Physician's signature Date