Approved, SCAO

PCS CODE: PFH/PAS/APM
TCS CODE: IPFH/PFH/PAS/APM

STATE OF MICHIGAN PROBATE COURT COUNTY OF OTTAWA	PETITION FOR MENTAL HEALTH TREATMENT ☐ AMENDED	FILE NO.

In the matter of _____ XXX-XX-____
First, middle, and last name — Last four digits of SSN

Court ORI	Date of birth	Place of birth	Race	Sex
MI700023J				

1. I, _____ (Name (type or print)), an adult _____ (specify whether a relative, neighbor, peace officer, etc.) petition because I believe the individual named above needs treatment.

2. The individual was born _____ (Date), has a permanent residence in _____

   County at _____ (Street address, City, State, ZIP)

   and can presently be found at _____ (Facility name or other address).

   ☐ This petition is for a person who was found not guilty by reason of insanity in this county (NGRI).

3. I believe the individual has mental illness and

   ☐ a. as a result of that mental illness, the individual can reasonably be expected within the near future to intentionally or unintentionally seriously physically injure self or others, and has engaged in an act or acts or made significant threats that are substantially supportive of this expectation.

   ☐ b. as a result of that mental illness, the individual is unable to attend to those basic physical needs that must be attended to in order to avoid serious harm in the near future, and has demonstrated that inability by failing to attend to those basic physical needs.

   ☐ c. the individual's judgment is so impaired by that mental illness, and whose lack of understanding of the need for treatment has caused him or her to demonstrate an unwillingness to voluntarily participate in or adhere to treatment that is necessary, on the basis of competent clinical opinion, to prevent a relapse or harmful deterioration of his or her condition, and presents a substantial risk of significant physical or mental harm to the individual or others.

4. The conclusions stated above are based on

   a. my personal observation of the person doing the following acts and saying the following things:

   _____

   _____

   b. the following conduct and statements that others have seen or heard and have told me about:

   _____

   _____

   by: _____
   Witness name — Complete address — Telephone no.

(SEE SECOND PAGE)

USE NOTE: If this form is being filed in the circuit court family division, please enter the court name and county in the upper left-hand corner of the form.

Do not write below this line - For court use only

MCL 330.1100a(29), MCL 330.1401, MCL 330.1423, MCL 330.1427, MCL 330.1434, MCL 330.1438, MCL 330.2050, MCR 5.125(C)(18)

5. The persons interested in these proceedings are:

NAME	RELATIONSHIP	ADDRESS	TELEPHONE
	Spouse		
	Guardian*		

*(Specify the county where the guardianship was established and the case number.) _____

6. The individual ☐ is ☐ is not a veteran.

☐ 7. Attached is a
- ☐ clinical certificate by a physician or licensed psychologist taken within the last 72 hours.
- ☐ clinical certificate by a psychiatrist taken within the last 72 hours.
- ☐ no clinical certificate is attached because only assisted outpatient treatment is requested.

☐ 8. (For hospitalization and combined treatment only.) An examination could not be secured because _____

_____

I request:
- ☐ a. the individual be examined at _____, the preadmission screening unit or hospital designated by the community mental health services program.
- ☐ b. a peace officer take the individual into protective custody and transport the individual to _____

_____.

9. I request the court to determine the individual to be a person requiring treatment and

- ☐ a. order appropriate mental health treatment including hospitalization or a combination of hospitalization and assisted outpatient treatment.
- ☐ b. order that the individual participate in assisted outpatient treatment without hospitalization.

☐ 10. I request the individual be hospitalized pending a hearing.

I declare under the penalties of perjury that this petition has been examined by me and that its contents are true to the best of my information, knowledge, and belief.

_____ _____
Signature of attorney Date

_____ _____
Name (type or print) Bar no. Signature of petitioner

_____ _____
Address Address

_____ _____
City, state, zip Telephone no. City, state, zip

_____ _____
Home telephone no. Work telephone no.

FOR HOSPITAL USE ONLY

This petition for mental health treatment was received by the hospital on _____ (Date) at _____ (Time).

_____
Signature of hospital representative

STATE OF MICHIGAN PROBATE COURT COUNTY OF OTTAWA	NOTICE OF INABILITY TO SECURE EVALUATION/EXAMINATION	FILE NO.

In the matter of _____
First, middle, and last name

1. A petition for mental health treatment was filed on _____ .
Date
2. The individual has failed to make himself or herself available for an evaluation/examination.
3. I am ☐ petitioner ☐ caseworker ☐ psychiatrist/psychologist/physician ☐ interested person
☐ other _____
4. The following reasonable attempts were made to obtain the individual's cooperation:

_____

_____

_____

_____
Date

_____
Signature

_____
Agency

_____
Address

_____
City, state, zip

_____
Telephone no.

Do not write below this line - For court use only

Identifying Information

NAME: _____

DATE OF BIRTH: _____

RACE: _____

SEX: _____

HEIGHT: _____

HAIR COLOR: _____

EYE COLOR: _____

ADDRESS OF LAST KNOWN LOCATION: _____

_____

_____