Model Form: Request for Hearing Form

STAFF: THIS IS AN IMPORTANT LEGAL DOCUMENT. FAX IMMEDIATELY TO 503-947-2955.

Patient Name: _____ Patient Number: _____

Date Notice of Hearing Rights Given to Patient: _____ Time: _____ am / pm

Date of Patient's Request: _____ Time: _____ am / pm

Check Box if Interpreter is Requested: ☐

REQUEST FOR HEARING FORM

If you do not agree with the hospital's decision to give you medication (or another significant procedure) you have the right to challenge this decision in front of a judge who does not work for the hospital.

I DO NOT WANT A HEARING TO CHALLENGE THE HOSPITAL'S DECISION TO MEDICATE ME (OR GIVE ME ANOTHER SIGNIFICANT PROCEDURE).
(If so, check this box and stop here) ☐

I WANT A HEARING TO CHALLENGE THE HOSPITAL'S DECISION TO MEDICATE ME (OR GIVE ME ANOTHER SIGNIFICANT PROCEDURE).
(If so, check this box and go on to the following questions)

☐

OSH STAFF REQUEST A HEARING on behalf of patient because OSH staff believes, based on patient's words and/or actions, that patient wants a hearing.

☐

I WANT SOMEONE TO HELP REPRESENT ME AT MY HEARING. (Check only one box if applicable**)**

☐ I would like a lawyer or authorized representative to be appointed to represent me at my hearing, at no cost to me.

☐ I will bring a lawyer or certified law student of my choice, at my own expense.
Name of lawyer or certified law student: _____
Contact information (phone, fax, or e-mail if possible): _____
_____

IF I AM NOT ALREADY RECEIVING THE PROPOSED MEDICATION, I WANT TO BE UN-MEDICATED (OR AS UN-MEDICATED AS IS SAFELY POSSIBLE) PRIOR TO A FINAL ORDER BEING ISSUED IN MY CASE.
(If so, check this box) ☐

Signature of Patient or Staff Person Who Completed Form: _____

Date: _____