

6954 East Broadway, Mount Pleasant MI 48858

(989) 775-4800

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

1. I, _____, make this notification as the
Name (type or print)

- agency.
- mental health professional who is supervising the individual's assisted outpatient treatment program.
- individual.

2. The individual who is the subject of this notification was ordered to undergo a program of assisted outpatient treatment or combined hospitalization and assisted outpatient treatment.

- a. The assisted outpatient treatment has not been or will not be sufficient to prevent the individual from inflicting harm or injuries to self or others.
- b. The individual is not complying with the order for assisted outpatient treatment or combined hospitalization and assisted outpatient treatment.
- c. I believe that my assisted outpatient treatment program is not appropriate.

3. The individual was in the hospital _____ days for mental health treatment. The individual needs immediate hospitalization.

4. This conclusion is based upon

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

- b. conduct and statements seen or heard by others and related to me:

State the conduct and statements and the name, address, and telephone number of each witness.

5. A psychiatrist has ordered the individual to return to the hospital.

6. I request the court to modify its last order of assisted outpatient treatment

- combined hospitalization and assisted outpatient treatment to direct the individual to:

- a. undergo another assisted outpatient treatment program.
- b. undergo hospitalization or combined hospitalization and assisted outpatient treatment, with hospitalization not to exceed _____ days.
- c. be transported to the hospital by a peace officer if the individual refuses to comply with the psychiatrist's order to return to the hospital.

Date

Signature

Title

Business Address

Agency

City, state, zip

Telephone no.