OKLAHOMA DEPARTMENT OF CORRECTIONS

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Correctional Center

Notice of Hearing to Consider Recommendation of Involuntary Administration of Psychotropic Medication

TO: ______________________________ ____________________ ____________________

Inmate Name ODOC Number Date

You have been diagnosed as suffering from: ____

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The following psychotropic medication(s) have been prescribed to treat your illness:

Name of Medication	Dose	Frequency	Route

You have refused to accept the prescribed medication(s). The reason for the recommendation of involuntary medication(s) is/are as follows:

- ☐ A substantial risk of serious harm to self
- ☐ A substantial risk of serious harm to others
- ☐ A substantial risk of significant property damage that may result in harm to self/others
- ☐ A gravely disabled person

A Medication Review Committee at this institution will conduct a hearing in accordance with the Department of Corrections OP-140652 entitled "Involuntary Psychotropic Medication in Non-Emergency Situations" to consider the recommendation on ________________________, at __________________________.

________________________________ has been assigned as a staff representative to assist you at the hearing and will contact you shortly to discuss this matter.

You have the right to refuse the prescribed medication until the Medication Review Committee reaches a decision. However, health care providers are not prevented from taking appropriate actions if you require mental health care on an emergency basis before the Medication Review Committee reaches a decision. Under such circumstances, health care providers will proceed in accordance with policies and procedures governing the provision of emergency mental health care, including, but not limited to, commitment to a hospital for inpatient mental health treatment.

Notice of Hearing to Consider Recommendation of Involuntary Administration of Psychotropic Medication

Inmate Name: ____ ODOC Number: ________________

You have the following rights at the Involuntary Medication Hearing:

1. Written notice, at least 24 hours prior to the hearing, of the date, time, and location of the hearing.
2. To be present at the hearing, subject to the rules of the Chair of the Medication Review Committee.
3. To have assistance from a staff representative to explain the nature and purpose of the hearing and to assist you in presenting your objection(s) to involuntary medication. If you are unable to attend the hearing, the staff representative will exercise your rights on your behalf.
4. To be unmedicated, if so requested, on the day of the hearing.
5. To present alternatives to involuntary medication at the hearing.
6. To present information and call witnesses at the hearing, subject to the rules of the Chair of the Medication Review Committee.
7. To cross-examine witnesses supporting involuntary medication, subject to the rules of the Chair of the Medication Review Committee.
8. To appeal the Medication Review Committee decision, if the decision authorizes involuntary medication.
9. To have a staff representative assist in the appeal process.
10. To have a copy of the Medication Review Committee's written decision.

The Medication Review Committee will, within 24 hours of the rendering of a decision, provide you with written notice of its decision and the reasons supporting the decision.

___________________________________	___________________________
Chairperson, Medication Review Committee	Date

A copy of this report was delivered to the above inmate/patient at least 24 hours prior to the involuntary medication hearing by:

__________________________	__________________________	__________________________
Printed Name	Signature	Position

Date: ____________________________ Time: ____________________________

cc: Medical File
Facility Head
Chair