PCS Code: RTD
TCS Code: RDHC

STATE OF MICHIGAN PROBATE COURT COUNTY	REQUEST TO DEFER HEARING ON COMMITMENT	CASE NO. and JUDGE

Court address | Court telephone no.

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

PLEASE TYPE OR PRINT CLEARLY

1. I state that I have met with my legal counsel, a representative from the community mental health program, and a member of the treatment team assigned by the hospital. I agree to one of the following:

   ☐ a. Inpatient hospital treatment not to exceed 60 days.

   ☐ b. Outpatient treatment not to exceed 180 days.

   ☐ c. Combined hospitalization and outpatient treatment up to 180 days with hospitalization not to exceed 60 days.

2. The treatment program will be as follows:

   Hospitalization: _____

   Outpatient treatment under the supervision of: (insert CMH provider information) _____

   _____

   ☐ case management plan
   ☐ case management services
   ☐ all services recommended by the treatment provider
   ☐ medication
   ☐ blood or urinalysis tests to determine compliance with or effectiveness of prescribed medication
   ☐ individual therapy ☐ group therapy ☐ individual and group therapy
   ☐ day programs ☐ partial day programs
   ☐ educational training ☐ vocational training
   ☐ supervised living
   ☐ assertive community treatment team services
   ☐ substance use disorder treatment ☐ substance use disorder testing
   ☐ other services _____

3. I request that the court hearing be deferred for not longer than 60 days from today if I have chosen to remain hospitalized, or 180 days from today if I have chosen outpatient treatment or a combination of hospitalization and outpatient treatment.

4. I understand that I may refuse this treatment at any time during this deferral period and demand a court hearing.

_____ Patient's signature and date

_____ Witness/Legal counsel | Bar no.

Deferral meeting attendees:

_____ CMH representative

_____ Hospital team member

_____ Patient requested attendee

_____ Other