

**MEDICAL TREATMENT  
AND DETENTION PETITION**

Commonwealth of Virginia VA. CODE §§ 37.2-1100, -1101, -1104

Case No. ....

Circuit Court  
 General District Court

.....  
CITY OR COUNTY

.....  
NAME OF RESPONDENT

.....  
ADDRESS OF RESPONDENT

1. CHECK ONE

A. I respectfully petition this court to authorize treatment for a mental or physical disorder on behalf of respondent and state that:

The respondent is an adult in need of treatment of the following physical or mental disorder or impairment:

.....  
It is my opinion that the respondent is incapable of making an informed decision on the treatment of the above-described mental or physical disorder, or is physically or mentally incapable of communicating such a decision on the treatment of the above-described physical or mental disorder because of the following:

physical or mental disorder or impairment: .....

The proposed treatment is in the best interest of the respondent.

The respondent is residing or is located in this city or county, or the proposed place of treatment is located in this city or county.

I understand that a person with dysphasia or other communication disorder who is mentally competent and able to communicate shall not be considered incapable of giving informed consent by law and that the respondent is not such a person to the best of my knowledge.

OR

B. I respectfully petition this court to authorize continued treatment for a mental or physical disorder on behalf of respondent as an extension of the court's prior authorization of temporary detention of the respondent for testing, observation or treatment pursuant to Va. Code § 37.2-1104. As such, facts previously alleged are attached and

incorporated herein and I further state that:

.....  
2. The respondent  is  is not a patient in a hospital or an individual receiving services in a facility operated by the Department of Behavioral Health and Developmental Services.

3. To the best of my knowledge, the respondent  has  does not have a guardian or legally authorized representative.

4. In my opinion, and the respondent is unlikely to become capable of making an informed decision or of communicating an informed decision within the time required for decision.

.....  
DATE

.....  
PETITIONER

.....  
PRINT NAME

.....  
ADDRESS/TELEPHONE NUMBER OF PETITIONER

**NOTICE:** Judicial authorization for treatment is not required for a person for whom consent or authorization has been granted or issued or may be obtained in accordance with the Health Care Decisions Act, Va. Code §§ 54.1-2981 to 54.0-2993.

I certify that I have delivered or mailed the respondent and, as whereabouts are known, the respondent's next of kin a certified copy of this petition.

Respondent is a patient in a hospital or an individual receiving services in a facility operated by the Department of Behavioral Health and Developmental Services and such person has no known guardian or legally authorized representative. I certify that I have delivered or mailed the respondent a certified copy of this petition.

.....  
DATE

.....  
 CLERK

.....  
 PETITIONER