Date: _____
Case Number: _____

Physician Request for 90 Day Continuance

Name of Person: _____

To: The Mental Health Board of the Fourth Judicial District, Douglas County, Nebraska

The above names person was admitted to:

_____ **on** _____**.**
(Treatment Facility) (date)

I am requesting the Board of Mental Health Petition not be scheduled for hearing and a 90 day Continuance be granted for the following reasons:
_____

_____

_____

_____

The person will be residing at:
_____
_____

And can be contacted by phone at: _____

Proposed Post-Hospitalization treatment plan in the least restrictive environment (please include interventions and frequency of visits)**:**
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Name of Person: _____
Case Number: _____
Date of Birth: _____

Contact information for other providers and agencies involved in this person's treatment (please include provider name, agency/practice, address, city, state, zip code, phone and fax numbers)**:**

_____
_____
_____
_____
_____
_____

Continuity of Care

☐ **The undersigned will continue to be the provider of record for this person and will continue to provide care until such time as the care has been transferred to another provider.**

☐ **The undersigned has made arrangements to transfer the care of this person to:**

Provider Name: _____
Address: _____
_____
Phone Number: _____

The first appointment is scheduled for: _____ (date)
_____ (time)

All providers agree to follow the expectations of the Board of Mental Health.

Approval

I understand that the hold placed on this person will not be lifted until the Board of Mental Health receives and approves this request.

I spoke with Deputy County Attorney: _____
and Assistant Public Defender: _____
Both have given verbal approval of this 90-day continuance request.

Name of Person: _____
Case Number: _____
Date of Birth: _____

Treating Physician Signature:

Physician Name (print): _____
Title: _____
Phone Number: _____
Fax Number: _____
Facility: _____
Address: _____
City, State, Zip Code: _____

Signature: _____
Date: _____

Patient Signature:
I have agreed to the terms and conditions of the voluntary treatment plan outlined above. I understand that if I do not fully comply with my treatment plan, the County Attorney may pursue civil commitments against me.

Signature: _____
Date: _____