APPLICATION FOR VOLUNTARY ADMISSION

Osawatomie State Hospital
Osawatomie, KS 66064-0500

_____ _____
Name of Proposed Patient County of Residence

_____
(address) (city) (state) (zip code)

I, the undersigned, apply for voluntary admission for care and treatment at Osawatomie State Hospital. I understand I may not leave the hospital without consent of the head of the hospital until three (3) days, excluding Saturdays, Sundays, and legal holidays, after I have submitted a written request for discharge. I understand that I will be charged for services provided by this hospital.

I understand that the head of this treatment facility or other person(s) may file a petition for determination of mental illness with respect to a voluntary patient who is refusing reasonable treatment efforts and is likely to cause harm to self or others if discharged.

I understand that treatment at Osawatomie State Hospital includes medication and group therapies. I also understand that, at the discretion of my physician, I may be subject to treatment by restrictions or restraints, including but not limited to confinement in a locked room, bodily restraint, or both, prescribed in accordance with Kansas Law.

_____ _____
Date Signature of Applicant

Authority: ☐ Proposed Patient ☐ Guardian - with court order, including provisions of (KSA 59-3077).

_____
(address) **(If different from above)** (city) (state) (zip code)

TO BE COMPLETED BY PHYSICIAN

I have examined the above named patient, and it is my opinion he/she:

☐ is in need of inpatient psychiatric care and treatment,

☐ has the capacity to consent to care and treatment, and

☐ is agreeing to receive care and treatment.

Note: All three conditions must be met to accept patient for voluntary admission.

_____ _____
Date Signature of Physician