STATE OF WISCONSIN, CIRCUIT COURT, _____ COUNTY

IN THE MATTER OF THE CONDITION OF

_____
Name of Subject

_____
Date of Birth

Statement of Petition For Review of Admission (§51.13, Wis. Stats.)

Case No. _____

- ***File this statement with the court within three (3) days after admission or an application for admission has been executed, whichever is sooner. The Court must either approve the admission within 5 after filing the Petition or hold a hearing within seven (7) days after admission or an application for admission has been executed.***
- ***A copy of the application for admission and any relevant professional evaluations must be attached.***
- ***Please print or type all information below. All blanks must be filled in.***

I am a treatment director/treatment director's designee of [Mental Health facility or Facility for Developmentally Disabled] _____ and state:

☐ The minor, 14 years of age or older, refuses consent for admission.
☐ The minor, any age, exhibits, verbally and/or behaviorally, refusal of consent for admission.
☐ The minor, minor's counsel, parent, or guardian requests a hearing.
☐ The minor's inpatient psychiatric hospitalization exceeds 12 days.
☐ The minor has been hospitalized, psychiatrically, within past 120 days.
☐ The minor, who is developmentally disabled, is to be admitted for a stay exceeding 12 days.

Date of admission: _____. Anticipated date of discharge: _____.

Patient's Street Address	City	County	State/Zipcode
Patient's Legal Guardian's Name(s) and Street Address	City	County	State/Zipcode

I am a treatment director/treatment director's designee and have reason to believe:

1. The minor is in need of psychiatric services, or services for developmental disability, alcoholism, or drug abuse based on the following facts:

   _____
   _____
   _____
   _____
   _____
   _____

2. Inpatient treatment in this inpatient facility is appropriate based on the following facts:

   _____
   _____
   _____
   _____
   _____

3. Inpatient care in this facility is the least restrictive setting consistent with the treatment needs of the minor based on the following considerations:

   _____
   _____
   _____
   _____

4. The minor has expressed his or her wishes regarding inpatient treatment at this facility through the following statement(s) and/or behaviors:

State of _____
County of _____
Subscribed and sworn to before me on _____

_____
Notary Public/Court Official

_____
Name Printed or Typed

My commission/term expires: _____

▶ _____
Signature of Treatment Director or Designee

_____
Name Printed or Typed

_____
Date

DISTRIBUTION:
1. Court
2. Minor
3. Parent(s)/Legal Guardian(s)
4. Division of Disability and Elder Services