FORM 12-1

Request for Voluntary Admission and Authorization for Treatment

Psychiatric Unit: _____

I hereby request admission to the above-named psychiatric unit as a voluntary patient. I consent to the care and treatment ordered by my attending physician or his or her associates. I understand that these physicians are independent medical practitioners and are not employees or agents of the hospital.

If my request is granted, I agree to conform to all the rules and regulations of the unit. If I wish to leave the hospital, I will give notice of my desire to leave to a hospital staff member and will complete all usual discharge or temporary absence procedures.

I understand that the hospital may inventory my personal belongings and possessions and remove items it considers potentially dangerous to my safety and welfare, or to the safety and welfare of other patients, visitors, or hospital staff.

I understand that my attending physician may wish to permit me the maximum amount of freedom of action commensurate with my condition, as this may be an important factor in my treatment program. This freedom of action may lead to possible self-injury and I release the hospital, its employees and agents, as well as my attending physician or his or her associates, from any and all responsibility in case such freedom leads to injury, except where the injury was the proximate result of negligence on the part of the hospital, its employees and agents, or my attending physician and his or her associates.

Date: _____ Time: _____ AM / PM

Signature: _____
(patient/legal representative)

If signed by someone other than patient, indicate relationship: _____

Print name: _____
(legal representative)

(over)

Certificate of Attending Physician

I hereby certify that I am the attending physician of the above-named patient, that I have examined the patient with reference to mental condition and, based on that examination, it is my opinion that the patient understands the nature of the admission to the psychiatric unit of this hospital and the care and treatment to be rendered, and that the patient was mentally competent at the time of the examination to make this application for admission.

Additional comments: _____

_____

Date: _____ Time: _____ AM / PM

Signature: _____
(physician)

Print name: _____
(physician)

FORM 12-1S

Solicitud de Admisión Voluntaria y Autorización Para el Tratamiento

Unidad psiquiátrica: _____

Por la presente solicito admisión a la unidad psiquiátrica arriba mencionada como paciente voluntario. Me someto al cuidado y tratamiento solicitado por el médico que me atiende o sus asociados. Entiendo que estos médicos son practicantes independientes y no son empleados o agentes del hospital.

Si se concede mi solicitud, me comprometo a cumplir con todas las normas y los reglamentos de la unidad. En el caso de que desee dejar el hospital, informaré sobre mi deseo de irme a un miembro del personal del hospital y llevaré a cabo todos los procedimientos normales para que me den de alta o la ausencia temporal.

Entiendo que el hospital puede hacer un inventario de mis efectos personales y pertenencias, y quitarme los elementos que considere potencialmente peligrosos para mi seguridad y bienestar, o para la seguridad y el bienestar de otros pacientes, visitantes o miembros del personal del hospital.

Entiendo que el médico que me atiende puede considerar conveniente permitirme la máxima cantidad de libertad de acción que sea acorde a mi enfermedad, ya que esto puede ser un factor importante en mi programa de tratamiento. Esta libertad de acción podría conducirme a posibles autolesiones, y eximo al hospital, a sus empleados y agentes, y al médico que me atiende o a sus colaboradores de toda responsabilidad en caso de que tal libertad me conduzca a lesiones, excepto si la lesión fuera consecuencia inmediata de la negligencia por parte del hospital, sus empleados y agentes, o del médico que me atiende y sus colaboradores.

Fecha: _____ Hora: _____ AM / PM

Firma: _____
(paciente/representante legal)

En caso de que lo firmase una persona que no sea el paciente, indique la relación: _____

Nombre en letra de imprenta: _____
(representante legal)

(sobre)

Certificate of Attending Physician

I hereby certify that I am the attending physician of the above-named patient, that I have examined the patient with reference to mental condition and, based on that examination, it is my opinion that the patient understands the nature of the admission to the psychiatric unit of this hospital and the care and treatment to be rendered, and that the patient was mentally competent at the time of the examination to make this application for admission.

Additional comments: _____

_____

Date: _____ Time: _____ AM / PM

Signature: _____
(physician)

Print name: _____
(physician)