I-71.1 Attachment A
Effective: 8/7/2013
Reviewed: 07/2021

REQUEST FOR COMPELLED MEDICAL TREATMENT (not psychiatric)

NAME OF PATIENT: _____ TDCJ NUMBER: _____ DATE OF BIRTH: _____

FACILITY OF ASSIGNMENT: _____ FACILITY OF INPATIENT ASSIGNMENT _____

MEDICAL/MENTAL HEALTH CONDITIONS UNDER TREATMENT (DESCRIBE):

CONDITION REQUIRING COMPELLED TREATMENT:

SUSPECTED REASON PATIENT UNABLE TO MAKE RATIONAL DECISION TO APPROVE THE TREATMENT AT THE PRESENT TIME:

PROPOSED REASON THE TREATMENT IS NECESSARY, REASONABLE AND IMPORTANT:

_____ _____

PROPONENT PHYSICIAN

_____

DATE OF REQUEST

REVIEWING PHYSICIAN

_____

DATE OF REVIEW

REVIEWED BY A MEDICAL DIRECTOR:

_____

DATE: _____

RECOMMENDED ACTION: _____

REVIEW BY TDCJ HEALTH SERVICES:

PRINT NAME: _____

TITLE: _____

SIGNATURE: _____

DATE: _____

COPY TO: DIVISION DIRECTOR FOR HEALTH SERVICES
UNIVERSITY MEDICAL DIRECTOR

ORIGINAL TO: INMATE HEALTH RECORD