

**PROBATE COURT
JEFFERSON COUNTY COURTHOUSE
BIRMINGHAM, ALABAMA**

By signing this Petition you are asking the Court to have this person evaluated for possible commitment to the Alabama State Department of Mental Health for treatment.

As a result of the Petition, **this person could be committed to the custody of Bryce Hospital, the V.A. Hospital in Tuscaloosa, Alabama, or any other facility operated by the Alabama State Department of Mental Health.**

I understand that a probable cause hearing concerning this petition will be scheduled within one week after the petition is activated; that ***I MUST*** be present at such hearing, and that I will be subject to sanctions by the Court upon my failure to appear.

Furthermore, I understand that by signing the Pauper's Oath, I am requesting of the Court to be relieved of the payment of Court costs and attorney fees. However, I understand that the Court is not responsible for any hospital costs accrued during this process.

Petitioner

Petitioner

Address

Address

City State Zip Code

City State Zip Code

Home Phone Number

Home Phone Number

Work Phone Number

Work Phone Number

CASE NO. _____

RESPONDENT _____

PETITION

TO THE HONORABLE ALAN L. KING, JUDGE OF PROBATE

COME(S) NOW _____
and petition(s) this Honorable Court, under the provisions of the laws of the State of Alabama in accordance with § 22-52-1 et seq.,
Code of Alabama 1975, to order the Sheriff of Jefferson County to take into custody _____
_____ (who is hereinafter referred to as respondent)

and whose approximate physical characteristics are as follows:

Height _____ Ft. _____ In.; Weight _____ Lbs.; Age _____ Yrs.; Sex _____ Race _____

who is presently located at _____

_____ and, after proper investigation and hearings, to find
that the said respondent is mentally ill and to commit the said respondent to the custody of the Alabama Department of Mental Health.

Petitioner(s) relationship with the said respondent is

As grounds for said Petitioner(s) say(s):

1. That the Petitioner(s) has reason to believe that said respondent is mentally ill; that as a result of the mental illness, the respondent poses a real and present threat of substantial harm to him (her) self and/or to others; that as a result of the mental illness, the respondent will, if not treated, continue to suffer mental distress and will continue to experience deterioration of the ability to function independently, and the respondent is unable to make a rational and informed decision as to whether or not treatment for mental illness would be desirable, that commitment is the least restrictive alternative that is necessary and available for the respondents illness.

2. That a threat of substantial harm to the respondent or to others has been evidenced by the following recent behavior, acts, attempts of threats: (please set out what happened, and when and where it happened):

3. That the names and addresses, if known, of the respondent's spouse, legal counsel or next of kin, are:

4. That the persons shown below have knowledge of the act(s) set out in the preceding paragraph; List Names, Addresses and Telephone Numbers (both work and residence, if known):

FULL NAME	ADDRESS	TELEPHONE NUMBER

Respectfully submitted on this the _____ day of _____, 20_____.

Petitioner

Petitioner's Attorney or Co-Petitioner

The State of Alabama
JEFFERSON COUNTY

The Petitioner(s) whose name(s) is (are) signed above, has duly sworn, deposes and says on oath that the facts alleged in the Petition above are true and correct.

Petitioner(s)

Sworn to and subscribed before me, the undersigned authority,
on this the _____ day of _____, 20_____.

(Judge of Probate) (Notary Public) (Chief Clerk)

The State of Alabama
JEFFERSON COUNTY

PROBATE COURT

Case No. _____

IN THE MATTER OF THE COMMITMENT OF

ALLEGED TO BE MENTALLY ILL

Before me, the undersigned, a Notary Public in the said County and said State personally appeared before me

Petitioner(s) in the aforementioned cause, who after being duly sworn by oath, depose(s) and say(s) that _____ he is an indigent person(s) wholly without funds to pay fees and other costs incurred in this litigation and, therefore, pray(s) that _____ he be allowed to proceed under the Pauper's Act of the State of Alabama.

Sworn to and subscribed before me on this
the _____ day of _____, 20 _____.

Notary Public

PROBATE - 167

PAUPER'S OATH

CONFIDENTIAL: Unauthorized disclosure or copying is prohibited

Name : _____

Date of Birth : _____

Race : _____ Sex : _____

Marital Status : _____

Social Security # : _____

BRYCE HOSPITAL

PERSONAL HISTORY

INSTRUCTIONS: Please fill out completely and return to: Bryce Hospital
Tuscaloosa, Alabama 35401

Patient's Address : _____ Telephone : _____

Spouse's Name : _____

Address : _____

Next of Kin : _____ Telephone : _____

Address : _____

In Case of Emergency Notify : _____ Zip Code _____

Address : _____ Telephone : _____

Name and Address of Minor Children : _____

Father's Name : _____

Mother's Maiden Name : _____

Number of Brothers and Sisters : _____ Where does patient rank? _____

Religious Preference : _____ Education : _____

Name And Address of Minister, Priest or Rabbi : _____

Has patient ever been in another mental hospital or had psychiatric treatment by a psychiatrist, at a Mental Health Center, Clinic, etc.? Yes _____ No _____

If yes, name, address and when : _____

_____ Doctor _____

When did you notice patient's illness? _____

What changes in behavior began occurring? _____

In your own words, describe patient prior to present problem : _____

CONFIDENTIAL: Unauthorized disclosure or copying is prohibited

BRYCE HOSPITAL

PERSONAL HISTORY

Does patient have epilepsy? Yes _____ No _____. Treated by Physician? _____

What medication? _____

When was last seizure? _____

Has patient ever had any other convulsions, "fits," Unconscious spells? Yes _____ No _____

If yes, for how long? _____ How Often? _____

If yes, how long does one last? _____

Please describe these convulsions: _____

Has he ever had a severe head injury or any other kind of injury? Yes _____ No _____

When? _____ Describe this injury: _____

Where was he treated for this? _____

Has he ever had a serious illness or accident such as strokes, heart trouble, abnormal blood pressure, diabetes, syphilis, or other venereal disease? Yes _____ No _____

Any other? Yes _____ No _____. Specify: _____

Does he presently take medication for this? Yes _____ No _____ What _____

Is the patient allergic to any drugs? Yes _____ No _____ What _____

Are there any physical handicaps? Yes _____ No _____. If yes, what kind? _____

Has the patient had any operations? Yes _____ No _____ If yes, what kind? _____

Does the patient abuse drugs, including alcohol? Yes _____ No _____

If yes, which? _____

To what extent? _____

Has the patient ever been arrested? Yes _____ No _____. If yes, for what? _____

_____ Action Taken: _____

If you have any additional pertinent information please attach additional sheet of paper.

Filled in by: _____

Relationship: _____

Date: _____

CONFIDENTIAL: Unauthorized disclosure or copying is prohibited

BRYCE HOSPITAL

PRE-ADMISSION FINANCIAL STATEMENT

Patient's Name : _____ Social Security No . _____
Last First Middle

Date of Birth : _____ Patient's Usual Occupation : _____

Name and Address of Last Employer _____ Date Last Worked _____

Spouse's Name : _____ Social Security No . _____

Spouse's Address : _____

Source of Income :

- () Social Security Amount _____ Claim # _____
- () SSI Amount _____ Claim # _____
- () VA Amount _____ Claim # _____
- () Railroad Retirement Amount _____ Claim # _____
- () Civil Service Amount _____ Claim # _____
- () Other (Indicate source and amount) _____ Claim # _____

Name of Bank (s) _____ Account Number (s) _____

Name (s) on Bank Account (s) _____

Balance in Bank Account (s) _____

Describe any other Assets (such as stock, CD's, etc.) _____

Does patient own any property (including home) ? _____ (If so, indicate type of property and approximate value :)

Property Location : _____

Hospital Insurance : _____ Yes _____ No (If yes, complete the following :)

Group or Personal _____ Name of Insured: _____
Name and address of company: _____ Policy # _____

Does patient have Medicare : _____ Yes _____ No Claim # _____

Does patient have Medicaid : _____ Yes _____ No Claim # _____

Is patient a veteran : _____ Yes _____ No (If yes, complete the following :)

Branch of service : _____ Dates of service : _____
Serial # _____ Claim # _____ Type Discharge _____

Is patient a dependent of a veteran : _____ Yes _____ No (If yes, complete the following

Name of Veteran _____ Veteran's Claim # _____
Patient's relationship to veteran _____

Name, address and telephone number of correspondent _____

Phone No . _____ Area Code _____ Number _____

Completed by : _____ (Signature)

Relationship to patient _____ Date _____

Bryce Hospital is authorized to release certain information to any insurance company or third party payer for the purpose of settlement of my account. I consent only to the disclosure of services rendered and diagnosis regarding this hospitalization. This consent is for the duration of my treatment at Bryce Hospital unless expressly revoked by me at an earlier date. I understand that if any information relates to alcohol or drug use, the receiving party will be advised as to their confidentiality under Federal Law.

Witness : _____ Patient : _____

Date : _____ Date : _____