Sarpy County Board of Mental Health

Physician's Request For 90-Day Continuance

Date ___________________

____ was admitted to ______________________

on ______________________, 20___. I am requesting the Petition not be scheduled for hearing. I would like a 90-day continuance for the following reason(s):

____

____

____

The treatment plan is:

____

____

____

Patient will be residing at: ____

Physician responsible for follow-up treatment: ____

Address: ____

Phone No.: ________________________________ Fax No.: __________________________________

I understand that the hold placed on this patient will not be lifted until the Board of Mental Health receives this request.

I spoke with Deputy County Attorney: ____
and Public Defender: ____
and received verbal approval of this 90-day continuance.

Treating physician: _______________________________ Phone No.: ___________________________

I have agreed to the terms and conditions of the voluntary treatment plan outlined above. I understand that if I do not fully comply with my treatment plan, the County Attorney may pursue civil commitment against me.

Patient signature: ____ Date: ____________________

BOMH Chair: Phone No. (402) 331-8830
Fax No. (402) 339-2327

Public Defender: Phone No. (402) 593-5933
Fax No. (402) 593-5939

County Attorney: Phone No. (402) 593-2230
Fax No. (402) 593-4359