**Form 9**

Notification of Involuntary Hospitalization for Medical Care and Protection

Mr./Ms. (name of person hospitalized under medical care and protection)

Date (mm/dd/yyyy): / /

[Involuntary hospitalization for medical care and protection]

Involuntary hospitalization for medical care and protection refers to a system in which a patient is determined to have a mental disorder and needs to be hospitalized for medical care and protection as a result of a medical examination by a designated mental health physician or specified doctor. When the patient is unable to consent to hospitalization due to the mental disorder, and the consent of family members, etc. to be hospitalized is obtained, this allows for hospitalization for a set period of time (within three months from the start of involuntary hospitalization for medical care and protection until six months have passed, and within six months after six months have passed from the start of involuntary hospitalization for medical care and protection) under the Act on Mental Health and Welfare of Persons with Mental Disabilities (hereinafter referred to as "the Act"). However, if it is necessary to continue hospitalization, the period of hospitalization will be extended with the consent of the patient's family, or other suitable person.

As a result of your examination with a (☐ designated mental health physician / ☐ specified doctor), it has been determined that hospitalization was necessary for the following reasons and purposes. Therefore, you have been admitted to the hospital on ((mm/dd/yyyy): / / ) at ( : ☐AM, ☐PM).

Your involuntary hospitalization for medical care and protection is pursuant to the provisions of Article 33 [☐(1) Section 1, ☐(2) Section 2, ☐(3) Second part of Section 3] of the Act. If (1) or (2) is applicable, the period of your hospitalization is until ((mm/dd/yyyy): / / ), which is no more than three months from the date of hospitalization.

[Reason for hospitalization]

1. As a result of your medical examination, you have been determined to have the following condition(s).

(1) Hallucination and delusional state (during a hallucination or delusion, you have difficulty distinguishing them from reality)

(2) Psychomotor arousal state (drive and will are excited, easily excited, or difficult to control by yourself)

(3) Stupor (difficulty responding to the outside world due to strong inhibition of willpower and severe confusion)

(4) Depressed state (continuing low moods, pessimistic thoughts, loss of interest and joy, etc.)

(5) Manic state (continued high mood, increased activity, irritability, etc.)

(6) Delirium/drowsy state (awareness level is decreased due to a consciousness disorder)

(7) Dementia state (cognitive function has declined and is interfering with daily life in general)

(8) Residual condition such as schizophrenia (there is difficulty in activities for daily living, social judgment, and performance of other functions due to a disability)

(9) Other ( )

1. You have been hospitalized for the following reason(s).

As it is not possible to provide sufficient treatment or care in an outpatient setting, hospitalized care and protection is necessary in order to provide comprehensive medical care.

Hospitalization is required for diagnosis and treatment while ensuring your safety.

Other ( )

Continued on back.

[Your life during hospitalized care and protection]

1. While you are in the hospital, you can receive and send letters and postcards without any restrictions. However, if it is suspected that foreign matter is contained in any mail, we may ask you to open it in the presence of hospital staff, and the foreign matter may be placed in the custody of the hospital.
2. During your hospitalization, no restrictions are placed on telephone calls or meetings with employees of administrative agencies that defend human rights or lawyers representing you, as well as meetings with lawyers who will represent you at the request of you or your family, etc. However, telephone calls and meetings with other persons may be temporarily restricted by medical staff depending on your medical condition.
3. During your hospitalization, restrictions may be placed on your behavior when necessary for medical treatment.
4. During your hospitalization, we will review the necessity of your hospitalization regularly.
5. Within 7 days from the date of admission, a post-discharge life counselor will be appointed as a staff member who will respond to inquiries from you and your family regarding the post-discharge living environment and provide necessary information, advice, and assistance as needed.
6. If you wish to use nursing care insurance or disability welfare services, or if you have the need to do so, please contact the hospital staff such as a post-discharge life counselor, as we will introduce you to some consultation regarding nursing care and disability welfare.
7. We will make our best efforts to assist you towards your recovery during your hospitalization. If you have any questions or concerns, please speak to hospital staff without reservation.
8. If you are still unsatisfied with your hospitalization or treatment, you or your family, etc. can petition the prefectural governor to give orders to discharge you or make improvements to your treatment. If you would like to learn more about this option, please speak to hospital staff such as a post-discharge life counselor, or contact the following.

Contact information for the local government (including phone number)

1. If you feel you have been mistreated by hospital staff during your hospitalization, you can report it below. Also, if you see another patient being mistreated by hospital staff, please report it below.

Contact information for reporting mistreatment to the local government (including phone number)

Hospital Name:

Name of Administrator:

Name of Designated Physician/Specified Doctor:

Doctor in Charge (\*):

(\*) Indicate if the doctor in charge has already been determined, other than the designated physician, etc.