**Form 12-2**

Notification of Continued Involuntary Hospitalization for Medical Care and Protection

Mr./Ms. (name of family member of person hospitalized for medical care and protection)

Date (mm/dd/yyyy): / /

[Continued involuntary hospitalization period 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. 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.

The reasons why it is necessary to continue the hospitalization period of Mr./Ms. ( ) (name of the patient admitted to involuntary hospitalization for medical care and protection) (hereinafter "the Individual") who is currently hospitalized, the hospitalization period after continuation has been determined, and the handling of consent are as follows.

1. For the Individual who is currently hospitalized for medical care and protection, it is deemed necessary to continue hospitalization based on the provisions of Article 33, Section 6 of the Act for the following reasons and purposes.

[Reason(s) why it is necessary to continue hospitalization]

(1) As a result of your medical examination, the Individual has 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 ( )

(2) The Individual is required to remain 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 the Individual’s safety.

Other ( )

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1. The Discharge Support Board for Patients Hospitalized for Medical Care and Protection held discussions to facilitate the transition to life in the community.
2. The hospitalization period after continuation has been determined is until ((mm/dd/yyyy): / / ).
3. If you agree to this continuation, please fill out the necessary information on the attached consent form and submit it to the hospital. (It is possible to respond to the hospital by a method other than the consent form, such as by phone, but even in this case, you will need to submit the consent form at a later date.)
4. If you do not agree to this determination for continuation, please be sure to notify the hospital by phone or other means of your intention to disagree.
5. If you wish to neither agree nor disagree with this determination for continuation, please notify the hospital by phone or other means to that effect.

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| Hospital Name: |
| Name of Administrator: |
| Name of Designated Physician: |
| Doctor in Charge (\*): |

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