**Form 13**

Continuation of Involuntary Hospitalization for Medical Care and Protection - Family Member Consent

1. Patient with mental disabilities who are subject to consent regarding continuation of involuntary hospitalization for medical care and protection

|  |  |  |
| --- | --- | --- |
| Address | Post code: | |
| Furigana |  | |
| Full name |  | |
| Date of birth (mm/dd/yyyy) | | / / |

2. Matters to be declared by consenting parties regarding the continuation of involuntary hospitalization period for medical care and protection

|  |  |  |
| --- | --- | --- |
| Address | Post code: | Post code: |
| Furigana |  |  |
| Full name |  |  |
| Date of birth  (mm/dd/yyyy) | / / | / / |
| Relationship to the patient | | |
| 1 Spouse 2 Parent (□with / □without parental authority) 3 Grandparent, etc. 4 Child, grandchild  5 Sibling 6 Guardian or curator 7 Supporting person appointed by the family court ( )  (Date of appointment (mm/dd/yyyy): / / )  I declare that none of the following apply.  (1) A person who has filed a lawsuit with the patient, a spouse or direct blood relative of the person who has filed a lawsuit with the patient, (2) a legal representative, curator, or assistant who has been excused by the family court, (3) a person who has abused the patient, etc. (spousal violence, child abuse, elder abuse, abuse of persons with disabilities), (4) a person who is unable to recognize, judge, and communicate appropriately to express consent or disapproval due to impaired mental function, (5) minors | | |

\*As a general rule, both parents must sign the form if both parents have parental authority.

After confirming that the above is true, I agree to continue the period of hospitalization of the person described in 1 at your hospital.

To Hospital Administrator

Date (mm/dd/yyyy): / /

(Name of consenting party)

(Name of consenting party (if the persons with parental authority are both parents))