St. Clair County Community Mental Health Authority

Treatment Agreement

Case #: _____

I, _____agree that I will comply with the following treatment plan through St. Clair County Community Mental Health Services.

1. I agree to cooperate with the CMH program and treatment team assigned to me. This will initially be:

   _____

Further treatment will be determined by the Interdisciplinary Team as appropriate.

2. I agree to take my medications as prescribed by the CMH psychiatrist or by my private psychiatrist.

3. I agree not to drink alcohol or take any street drugs or non-prescribed medications while in treatment.

4. The duration of the Court Ordered Treatment is from _____to

   _____.

Individual Signature:_____Print Name:_____ Date:_____

Witness Signature:_____ Print Name:_____ Date:_____

A copy of this signed treatment agreement will be provided to Judge John D. Tomlinson, St. Clair County Probate Court as part of your Court Order.

Failure to comply with this Agreement may result in re-hospitalization.