

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
48 HOUR RULE – MEDICATION LISTING FORM

Date _____

Presiding Justice _____

Name of Court _____

Address _____

City/Town, State Zip Code _____

RE: _____

Dear Sir/Madam:

Please be informed that _____ has received the following medication(s):

This medication does not negatively affect the patient's ability to participate in the court proceeding or competently advise his/her attorney. Whatever mental impairment might exist is the result of the patient's mental condition and not the direct effect of this medication(s).

Respectfully,

Psychiatrist

Title