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Certificate of Professional Initiating Involuntary Examination

All sections of this form must be completed and legible (please print) Go To Page 2

I have personally examined (printed name of person) _____ at time _____ ☐ am ☐ pm (time must be within the preceding 48 hours) on (date) _____ in _____ County and that person appears to meet criteria for involuntary examination OR

I am a physician who has determined that (printed name of person) _____ has failed or has refused to comply with the treatment ordered by the court, and, in my clinical judgment, efforts were made to solicit compliance and the person appears to meet the criteria for involuntary examination. Section IV of this form is completed to document the requirements of the law.

This is to certify that my professional license number is: _____ and I am a (check one box):

☐ Psychiatrist ☐ Physician (non-psychiatric) ☐ Clinical Psychologist ☐ Psychiatric Nurse ☐ Clinical Social Worker
☐ Mental Health counselor ☐ Marriage and Family Therapist Each as defined in s.394.455, F.S.

Section I: CRITERIA

There is reason to believe person has a mental illness as defined in Section 394.455(18), Florida Statutes (excludes retardation or developmental disabilities, intoxication, or conditions manifested only by antisocial behavior or substance abuse impairment).

Diagnosis of Mental Illness is (list all mental health diagnoses applicable to this person):

DSM Code(s) (if known)

AND BECAUSE OF MENTAL ILLNESS

☐ A. Person has refused voluntary examination after conscientious explanation of disclosure of the purpose of examination

OR
Statute requires that at least one be checked, but both may be checked if both apply

☐ B. Person is unable to determine for himself/herself whether examination is necessary

☐ A. Without care and treatment the person is likely to suffer from neglect or refuse to care for himself/herself, and such neglect or refusal poses a real and present threat of substantial harm to his or her well-being and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services

AND EITHER

(A and/or B)

☐ B. There is substantial likelihood that without care or treatment the person will cause serious bodily harm to (check one or both):
☐ self ☐ others
in the near future, as evidenced by recent behaviors (describe in following sections)

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Section II: SUPPORTING EVIDENCE

My observations supporting these criteria including the person's behaviors and statements, specifically those related to suicidal ideation, previous suicide attempts, homicidal ideation or self-injury are as follows:

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Section III: OTHER INFORMATION

Other information, including source relied upon to reach this conclusion, is as follows. If information is obtained from other persons, describe these sources (e.g., reports of family, friends, other mental health professionals or law enforcement officers, as well as medical health records).

Section IV: NON-COMPLIANCE WITH INVOLUNTARY OUTPATIENT PLACEMENT ORDER

(Complete this section if you are a physician who is documenting non-compliance with an involuntary outpatient placement order.)

This is to certify that I am a physician, as defined in Florida Statutes 394.455(21), F.S., and in my clinical judgment, the person has failed or has refused to comply with the treatment ordered by the court, and the following efforts have been made to solicit compliance with the treatment plan:

Section V: INFORMATION FOR LAW ENFORCEMENT

Provide identifying information (if known) if needed by law enforcement to find the person so he/she may be taken into custody for examination:

Age:_____ ☐ Male ☐ Female Race/ethnicity:_____

Other details (such as height, weight, hair color, clothing worn when last seen, where last seen):

If relevant, information such as access to weapon, recent violence or pending criminal charges:

This form must be transported with the person to the receiving facility to be retained in the clinical record. Copies may be retained by the initiating professional and by the law enforcement agency transporting the person to the receiving facility.

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Section VI: SIGNATURE

Signature of Professional:_____ Date Signed:_____

Typed or Printed Name of Professional:_____ Phone: (_____)_____

Address of Professional:_____