FORM NO. MH-11
Revised 03/2000

APPLICATION FOR EMERGENCY EXAMINATION

To the Family Court comes_____
(Please print full name of applicant)

of_____
(Please print complete address of applicant)

Telephone Number_____

Relationship to or interest in proposed patient*_____

and makes application for the emergency examination of_____
(Please print full name of proposed person in need of treatment)

of_____
(Please print complete address of proposed person in need of treatment)

***NOTE:** Only the following persons may make application for an individual's emergency examination: a guardian, spouse, parent adult child, close adult relative, a responsible adult friend or person who has the individual in his or her charge or care (e.g. a superintendent of a correctional facility), a law enforcement officer, a licensed physician (**Caution:** same physician cannot be both applicant and certifying physician), a head of a hospital or his or her written designee, a selectman, a town health officer or a town service officer, or a mental health professional (i.e., a physician, psychologist, social worker, nurse or other qualified person designated by the Commissioner of Developmental and Mental Health Services).

REASON FOR APPLICATION: (State the facts which you have gathered either from your own personal observations or as reliably reported to you by another person which lead you to believe that the proposed patient is in need of emergency examination and which show that the person is a person in need of treatment.)
BE SPECIFIC!

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

(CONTINUE ON REVERSE SIDE)

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Revised 03/2000

(If additional space is required, please continue on a separate sheet of paper)

Signed under the penalties of perjury
pursuant to 18 V.S.A. Section 7612(d)(2)

Date of Application

Signature of Applicant

NOTE TO APPLICANT:

This application **MUST** accompany the proposed patient when he/she is to be taken to the hospital for an emergency examination. **If the proposed patient refused to submit to an examination by a licensed physician, you cannot use this form!** If the patient refuses examination, the applicant should consider applying to a judge for a Warrant for Immediate Examination under 18 V.S.A. §7505.

I hereby waive any right I have to receive a copy of the notice of hearing from the court pursuant to 18 V.S.A §7613. I understand that despite this waiver I may be called as a witness to testify at a hearing involving the above named proposed patient.

Signature of Applicant

FORM NO. MH-11B
Revised: 3/2000

PHYSICIAN'S CERTIFICATE
EMERGENCY EXAM

NOTE TO PHYSICIAN:

If you are considering the proposed patient's admission to a 72 hour hold program: To complete this form you must be a board certified or board eligible psychiatrist, a resident in psychiatry: ONLY THESE PHYSICIANS MAY ADMIT PROPOSED PATIENTS TO THE 72 HOUR HOLD PROGRAM.

If you are considering the proposed patient's admission to Vermont State Hospital: To complete this form you must be a board certified or board eligible psychiatrist, a resident in psychiatry, or a licensed physician designated by the Commissioner of Developmental and Mental Health Services as appropriate to complete Physician' Certificates. Complete Sections I and II.

SECTION I

I, the undersigned, hereby certify that I am a ***(please circle one)*** board certified psychiatrist / board eligible psychiatrist / resident in psychiatry/physician designated by Commissioner of Developmental and Mental Health Services as qualified to complete Physician's Certificate. I further state that I am duly licensed to practice medicine in the State of Vermont and I have made careful examination of the mental condition of

_____ **of** _____
(NAME) **(ADDRESS)**

in the County of_____, State of Vermont, and that I am of the opinion that **he/she** is a mentally ill person in need of treatment. The following information concerning the proposed patient and **his or her** family is submitted:

DATE OF BIRTH_____**PLACE OF BIRTH**:_____**SEX:**_____

MARITAL STATUS---Single, Married, Domestic Partner, Divorced, Separated, Widowed, Unknown (Circle One)

NAME AND ADDRESS OF SPOUSE/PARTNER, If any_____

_____

Can the patient speak and understand English?_____**If not, what language?**_____

NAME OF FATHER:_____**ADDRESS:**_____
(If deceased, so state)

MAIDEN NAME OF MOTHER:_____**ADDRESS:**_____
(If deceased, so state_____)

(CONTINUED ON REVERSE SIDE)

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SECTION I
(Continued)

1. The following data (A-D) is not required but should be provided if appropriate and available.

   (A) Alien Registration No:_____ (B) V.A. Claim No:_____

   (C) Medicare No:_____ (D) Medicaid No:_____

2. How long have you known the patient?_____

3. Does the patient have any serious physical illness?_____If so, describe_____

_____

_____

4. Has the patient been physically injured in the recent past?_____If so, when, how and to what extent_____

_____

5. List current medications and any drug sensitivities_____

_____

_____

6. Full name and address of guardian, if any, nearest relative or friend_____

_____

_____

_____

Relationship to/interest in patient_____

SECTION II
PHYSICIAN'S CERTIFICATE
EMERGENCY EXAMINATION

In my opinion this patient_____ is (A) not only mentally ill, but
(NAME)
(B) poses a danger of harm to him/herself or others and (C) should immediately be admitted to a designated hospital for an emergency examination. I believe the patient meets all three of the above criteria and base this opinion on the facts outlined below. (**NOTE:** For each of these three criteria, it is required that the physician identify separately facts observed by him or her and those reliably reported to him or her by others. In each case the source must be identified.)

7. What facts have been observed by yourself and/or reliably reported to you which lead you to believe that the patient is mentally ill? What did the patient say? What did the patient do?

Tentative Diagnosis_____

8. What facts have been observed by yourself and/or reliably reported to you which lead you to believe that as a result of the mental illness the patient poses a danger of harm to him/herself or others? What did the patient say or do? To whom specifically and in what way is the patient a danger?

(CONTINUED ON REVERSE SIDE)

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9. It is the obligation of the certifying physician to consider available alternative forms of care and treatment for the person's needs, without requiring hospitalization. List all steps taken in exploring alternative forms or care and treatment. (NOTE: Discussing available alternatives with a representative of an authorized screening agency may assist the physician in complying with this requirement. Screeners can be contacted twenty-four hours a day. For a current listing of the designated screening agents, call the Admissions Office at the Vermont State Hospital, telephone number 802-241-3054)

_____

_____

_____

_____

10. What medications or treatments were administered prior to transporting the patient to the hospital for an emergency examination?

_____

_____

Time administered_____ AM _____ PM

11. Name of person in the hospital Admissions Office (802-241-3054) you have spoken to.

_____

Signed under the penalties of perjury pursuant to 18 V.S.A. Section 7612(e)(1)

_____ _____

Date of Examination Signature of Physician

_____ _____

Time of Examination Please Print or Type Physician's Name

_____

Physician's Address

_____

Physician's Telephone Number

PHYSICIAN'S NOTE: The Application Form and Sections I and II of the Physician's Certificate must accompany the patient to the hospital for an emergency examination. When these forms are completed, the patient may be transported to the hospital.

I hereby waive any right I have to receive a copy of the notice of hearing from the Court pursuant to 18 V.S.A. §7613. I understand that despite this waiver I may be called to testify at a hearing involving the above named proposed patient.

_____

Signature