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| **NOTE: THIS CERTIFICATE EXPIRES THREE (3) CALENDAR DAYS AFTER THE DATE OF THE EXAM.** **A PERSON MAY NOT BE ADMITTED TO A HOSPITAL BASED ON THIS CERTIFICATE AFTER IT HAS EXPIRED.** |
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|  **PART II** | **PAGE 1** |
| **CERTIFICATE OF LICENSED PHYSICIAN** |
| **EXAMINATION FOR EMERGENCY ADMISSION** |
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|  |  |  |  |  |  |  |  |  |
| NAME OF PERSON EXAMINED |  | SEX |  | COUNTY OF RESIDENCE |  | DATE OF BIRTH |  | AGE |
|  |  |  |  |  |
| PLACE OF EXAMINATION |  |  |  | HOUR AND DATE OF EXAMINATION |
|  |  |  |  |  |
| I, THE UNDERSIGNED LICENSED PHYSICIAN, have examined the above-named person and am of the opinion that the said individual:  |
|  |
| IS MENTALLY ILL and because of this mental condition CURRENTLY POSES A SUBSTANTIAL RISK of physical harm to self and/or others to the extent that INVOLUNTARY EMERGENCY HOSPITALIZATION is recommended. |
|  |
| My recommendation for INVOLUNTARY EMERGENCY HOSPITALIZATION is based on the following symptoms and specific examples of behavior which indicate mental illness and probable risk of harm:  |
|  |  |  |
|  | [ ]  | Threats and/or attempts at suicide or serious bodily harm, |
|  | [ ]  | Homicidal or violent behaviors, |
|  | [ ]  | Self-neglect, inability to care for, and/or protect self if not immediately hospitalized, and/or  |
|  | [ ]  | Other:  |       |
|  |  |  |  |
| Provide your reasons for selecting the above boxes and the specific symptoms exhibited by the above-named person that contributed to your finding that he/she is in need of immediate psychiatric inpatient treatment:  |
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|       |
| Are there prior admissions to mental health treatment facilities?  | Where?  | When?  |
| [ ]  | **YES** | [ ]  | **NO** | [ ]  | **UNKNOWN** |       |       |
| Are there criminal charges?  | If yes, give details (including county and type of charge).  |
| [ ]  | **YES** | [ ]  | **NO** | [ ]  | **UNKNOWN** |       |
|  |
| The medical condition of the Patient is: |
|       |
|       |
|       |
|       |
|  |
| PAGE 1 AND PAGE 2 MUST BE COMPLETED. |
| All information MUST be typed or clearly printed. |

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| Is the patient medicated prior to transporting?  | If yes, give type, amount, route, and when last administered.  |
| [ ]  | **YES** | [ ]  | **NO** |       |
| Patient’s Current Medication:  |
|       |
| **HEALTH OF PATIENT**  |
| **Disease** | **Yes** | **No** | **Date(s)** | **Disease** | **Yes** | **No** | **Date(s)** | **Disease** | **Yes** | **No** | **Date(s)** |
| Paralysis or Crippled Limbs |  |  |  | Cancer |  |  |  | Homicidal or Suicidal Tendency |  |  |  |
| Blindness or Eye Trouble |  |  |  | TB or Lung Disease |  |  |  | Mental Retardation or Dementia |  |  |  |
| Deafness or Ear Trouble |  |  |  | Heart or High Blood Pressure |  |  |  | Syphilis |  |  |  |
| Epilepsy or Seizures |  |  |  | Tremors or Abnormal Movements |  |  |  | HIV |  |  |  |
| Diabetes |  |  |  | Hepatitis |  |  |  | Alcohol Abuse |  |  |  |
| Serious Allergies |  |  |  | Head injury |  |  |  | Drug Abuse |  |  |  |
|  |  |  |  |  |  |  |  |  | Type of Abuse: |  |
| Patient’s Operations:  |
|       |
| Name of Treatment Facility Accepting Admission: | Name of Treatment Facility Physician Authorizing Admission: |
|       |       |
|  |
| **PHYSICIAN’S VERIFICATION** |
|  |
| ON THE BASIS OF MY PERSONAL EXAMINATION, I BELIEVE THAT THE PERSON IS IN NEED OF INVOLUNTARY EMERGENCY PSYCHIATRIC HOSPITALIZATION. FURTHERMORE, THE PERSON HAS NO MEDICAL/SURGICAL CONDITIONS OR DISABILITIES THAT PRESENTLY REQUIRE A GENERAL HOSPITAL OR NURSING HOME LEVEL OF CARE AND IS MEDICALLY STABLE AND PHYSICALLY ABLE TO PARTICIPATE IN PSYCHIATRIC TREATMENT. I HAVE CONSULTED WITH THE ADMITTING PHYSICIAN OF THE RECEIVING HOSPITAL REGARDING THE APPROPRIATENESS OF ADMISSION AND THE PERSON’S MENTAL AND PHYSICAL TREATMENT NEEDS. |
|  |
| [ ]  | I have consulted with the local community mental health center regarding the commitment/admission process and the available treatment options and alternatives in lieu of hospitalization at a state psychiatric facility. (SC Code § 44-17-460)  |
|  | **OR** |
| [ ]  | I have not consulted with the local community mental health center, because (state a clinical reason for your failure to do so): |
|  |       |
|  |  |
| **THE PERSON THEREFORE NEEDS TO BE TRANSPORTED TO THE FOLLOWING FACILITY FOR INVOLUNTARY EMERGENCY ADMISSION:**  |
|       |  |       |
| NAME OF PSYCHIATRIC HOSPITAL |  | ADDRESS |
|  | , M.D. |       |  |  |       |
| SIGNATURE OF LICENSED PHYSICIAN |  | SC LICENSE NUMBER |  |  | NAME OF CENTER |
|       |  |       |  |  |  |
| TYPE OR PRINT NAME |  | PHONE NUMBER |  |  | SIGNATURE OF FACE TO FACE SCREENER AND DATE |
|       |  |  |       |
| ADDRESS |  |  | PRINT NAME OF SCREENER, TITLE AND ID # |
|  |
| **TO FRIENDS AND RELATIVES:** |
|  |
| It is the responsibility of an officer of the peace to provide timely transportation of the person alleged to be mentally ill to the designated mental health facility. However, by freely signing this statement, you can choose to assume that responsibility. Transportation must begin immediately. You are not entitled to any reimbursement from the State for the cost of such transportation. **This form must be hand delivered by you to the admissions office of the designated mental health facility at the time of admission.**  |
|       |  |  |
| DATE |  | SIGNATURE |
|  |  |  |
|  |
| **TO POLICE AND OTHER OFFICERS OF THE PEACE:** |
|  |
| THIS CERTIFICATE OF LICENSED PHYSICIAN AUTHORIZES AND REQUIRES YOU TO TAKE THE PROPOSED PATIENT INTO CUSTODY AND TRANSPORT HIM/HER TO THE HOSPITAL DESIGNATED BY THE CERTIFICATION PURSUANT TO SC CODE § 44-17-440, UNLESS A FRIEND OR RELATIVE HAS SIGNED ABOVE AND IS WILLING TO TRANSPORT THE PATIENT. **NO FURTHER ORDER IS REQUIRED FOR YOU TO TRANSPORT THIS PATIENT. HOWEVER, NO PERSON SHALL BE TAKEN INTO CUSTODY AFTER THE EXPIRATION OF THREE DAYS FROM THE DATE OF THIS CERTIFICATION.** ANY OFFICER ACTING IN ACCORDANCE WITH THE PROVISIONS AS SET FORTH ABOVE SHALL BE IMMUNE FROM CIVIL LIABILITY.  |