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| **NOTE: THIS CERTIFICATE EXPIRES FORTY-EIGHT HOURS 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 RESIDENSE |  | 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 chemically dependent, and as a result of this condition, poses a substantial risk of physical harm to self or others if not immediately provided with involuntary emergency care and treatment.  |
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| Based on my examination of the above-named person, I am of the opinion that the immediacy of the above-named person’s situation and the safety of the above-named person does not allow for initiation of judicial proceedings for an involuntary commitment as set forth in S.C. Code § 44-52-70. |
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| My recommendation for INVOLUNTARY EMERGENCY HOSPITALIZATION is based on the following symptoms and specific examples of behavior which indicate chemical dependency and probable risk of harm: |
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|  | [ ]  | Recent overt acts or recent expressed acts of violence; |
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|  | [ ]  | Episodes of recent serious physical problems related to the habitual and excessive use of drugs or alcohol, or both; |
|  |
|  | [ ]  | Incapacitation by drugs or alcohol, or both, on a habitual and excessive basis as evidenced by numerous appearances before the Probate Court within the preceding twelve months, repeated incidents involving law enforcement, and/or multiple prior treatment episodes; and/or |
|  |
|  |  [ ]  | Other:  |       |
|  |
| Provide your reasons for selecting the above boxes, the specific symptoms exhibited by the above-named person that contributed to your finding that he/she is in need of immediate chemical dependency inpatient treatment, as well as the type, amount, and frequency of the substances used:  |
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|       |
| Are there prior admissions to SCDMH or other chemical dependency treatment facilities? | Where? | When? |
| [ ]  | **YES** | [ ]  | **NO** | [ ]  | **UNKNOWN** |       |       |
| Are there prior admissions to SCDMH or other psychiatric treatment facilities? | Where? | When? |
| [ ]  | **YES** | [ ]  | **NO** | [ ]  | **UNKNOWN** |       |       |
| Are there criminal charges? | If yes, give details (including county and type of charge).  |
| [ ]  | **YES** | [ ]  | **NO** | [ ]  | **UNKNOWN** |       |
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| The medical condition of the Person is (include statement of need of medical detoxification): |
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|       |
|       |
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|       |
|       |
| **CERTIFICATE OF LICENSED PHYSICIAN** | **PAGE 2** |
| Is the patient medicated or under the influence of alcohol and/or drugs prior to transporting? | If yes, give type, amount, route, and when last administered.       |
| [ ]  | **YES** | [ ]  | **NO** |
| Prescribed medication(s) presently taking or within past three months:       |
| Blood Alcohol |       | Blood Pressure |       | Pulse |       | Temperature |       | Respiration |       |
|  |
| **HEALTH OF PATIENT** |
| **Disease** | **Yes** | **No** | **Date(s)** | **Disease** | **Yes** | **No** | **Dates(s)** | **Disease** | **Yes** | **No** | **Date(s)** |
| Paralysis or Crippled Limbs | **[ ]**  | **[ ]**  |       | Cancer | **[ ]**  | **[ ]**  |       | Intellectual Disability or Dementia | **[ ]**  | **[ ]**  |       |
| Blindness or Eye Trouble | **[ ]**  | **[ ]**  |       | TB or Lung Disease | **[ ]**  | **[ ]**  |       | Syphilis | **[ ]**  | **[ ]**  |       |
| Deafness or Ear Trouble | **[ ]**  | **[ ]**  |       | Heart or High Blood Pressure | **[ ]**  | **[ ]**  |       | HIV + | **[ ]**  | **[ ]**  |       |
| Epilepsy or Seizures | **[ ]**  | **[ ]**  |       | Tremors or Abnormal Movements | **[ ]**  | **[ ]**  |       | Homicidal or Suicidal Tendency | **[ ]**  | **[ ]**  |       |
| Diabetes | **[ ]**  | **[ ]**  |       | Hepatitis or Liver Disease | **[ ]**  | **[ ]**  |       | Details of any homicidal or suicidal episodes:      |
| Serious Allergies | **[ ]**  | **[ ]**  |       | Head injury | **[ ]**  | **[ ]**  |       |
| Delirium Tremens (DTs) | **[ ]**  | **[ ]**  |       | Alcohol Withdrawal | **[ ]**  | **[ ]**  |       | Drug Withdrawal | **[ ]**  | **[ ]**  |       |
| Patient’s Operations: |
| Name of Treatment Facility Accepting Admission:       | Name of Treatment Facility Physician or Staff Member Authorizing Admission:      |
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| **PHYSICIAN’S VERIFICATION** |
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| ON THE BASIS OF MY PERSONAL EXAMINATION, I BELIEVE THE CONDITION OF THIS PERSON REQUIRES INVOLUNTARY EMERGENCY ADMISSION FOR CHEMICAL DEPENDENCY TREATMENT. |
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| **[ ]**  | The person has no medical 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 chemical dependency treatment.  |
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| **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 |
|       | **, M.D.** |       |  |       |
| 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:** |
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| It is the responsibility of a law enforcement officer to provide timely transportation of the person alleged to be chemically dependent to the designated treatment 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 treatment 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 S.C. CODE § 44-52-50, 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 FORTY-EIGHT (48) HOURS FROM THE DATE OF THIS CERTIFICATION.** ANY OFFICER ACTING IN ACCORDANCE WITH THE PROVISIONS AS SET FORTH ABOVE SHALL BE IMMUNE FROM CIVIL LIABILITY. |