FORM NO. MH-11B
Revised: 10/2014

PHYSICIAN'S CERTIFICATE
EMERGENCY EXAM

NOTE TO PHYSICIAN:

If you are considering the proposed patient's admission to a hospital: To complete this form you must be a board-certified psychiatrist, a resident in psychiatry, or a licensed physician designated by the Commissioner of Mental Health as appropriate to complete Physician's Certificate: ONLY THESE PHYSICIANS MAY ADMIT PROPOSED PATIENTS INVOLUNTARILY TO A HOSPITAL.

Complete Sections I and II.

SECTION I

I, the undersigned, hereby certify that I am a ***(please check one)*** ☐ board-certified psychiatrist / ☐ resident in psychiatry / ☐ physician designated by the Commissioner of Mental Health as qualified to complete the 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 this person is a mentally ill person in need of treatment. The following information concerning the proposed patient is submitted:

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

MARITAL STATUS--- ☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Separated ☐ Widowed ☐ Unknown (Check 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)

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:_____

FORM NO. 11C
Revised: 10/2014

2. How long have you known the patient?_____

3. Does the patient have any serious physical illness(es)?_____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

In my opinion this proposed patient_____is
(NAME)
(A) mentally ill and (B) poses a danger of harm to him/herself or others, and (C) should be admitted immediately to a hospital for an emergency examination (second certification). I believe the proposed 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 instance, the source of the information must be identified.)

Tentative Diagnosis_____

_____

7. What facts have you observed and/or were reliably reported to you (identify separately) that lead you to believe that the proposed patient has a mental illness? What did the proposed patient say? What did the proposed patient do?

8. What facts have you observed and/or were reliably reported to you (please identify separately) that lead you to believe that the proposed patient poses a danger of harm to him/herself or others *as a result of the mental illness*? What did the proposed patient say or do? To whom, specifically, is the proposed patient a danger and in what way?

9. The law requires 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 of 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 24 hours a day. For a current listing of the designated screening agents, call the Admissions Office at the Vermont Psychiatric Care Hospital, telephone number 802-828-2799.)

FORM NO. MH-11E
Revised 09/2014

10. What medication(s) or treatment(s) were administered prior to transporting the patient to the hospital for an emergency examination?

_____

_____

_____

_____

Time administered: _____ A.M. _____ P.M.

11. Name of person in the hospital Admissions Office (802-828-2799) you spoke to:

_____

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

_____ _____

Date of Examination Signature of Physician

_____ _____

Time of Examination 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 proposed patient to the hospital for an emergency examination. When these forms are completed, the proposed 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