STATEMENT OF TREATING LICENSED INDEPENDENT PRACTITIONER PURSUANT TO 18 V.S.A. § 7620

CLIENT NAME: DOB:

CLIENT'S MAILING ADDRESS:

CLIENT'S TELEPHONE NUMBER:

I am the treating licensed independent practitioner for the above named patient, and it is my opinion that he or she is "a patient in need of further treatment" as that term is defined in 18 V.S.A. § 7101(16).

18 V.S.A. § 7101(16) "A patient in need of further treatment" means:

(A) A person in need of treatment; or

(B) A patient who is receiving adequate treatment, and who, if such treatment is discontinued, presents a substantial probability that in the near future his or her condition will deteriorate and he or she will become a person in need of treatment.

18 V.S.A. § 7101(17) "A person in need of treatment" means a person who is suffering from mental illness and, as a result of that mental illness, his or her capacity to exercise self-control, judgment, or discretion in the conduct of his or her affairs and social relations is so lessened that he or she poses a danger of harm to himself, to herself, or to others:

(A) A danger of harm to others may be shown by establishing that:

(i) he or she has inflicted or attempted to inflict bodily harm on another; or

(ii) by his or her threats or actions he or she has placed others in reasonable fear of physical harm to themselves; or

(iii) by his or her actions or inactions he or she has presented a danger to persons in his or her care.

(B) A danger of harm to himself or herself may be shown by establishing that:

(i) he or she has threatened or attempted suicide or serious bodily harm; or

(ii) he or she has behaved in such a manner as to indicate that he or she is unable, without supervision and the assistance of others, to satisfy his or her need for nourishment, personal or medical care, shelter, or self-protection and safety, so that it is probable that death, substantial physical bodily injury, serious mental deterioration, or serious physical debilitation or disease will ensue unless adequate treatment is afforded.

_____
Signature / Date

_____
Print Name

Circle One: physician / nurse practitioner

_____
Address

_____
Telephone Number

ONH TREATMENT REVIEW FORM

(Description of facts justifying continued court ordered treatment)

CLIENT NAME: **DOB:**

CLIENT'S MAILING ADDRESS:

CLIENT'S TELEPHONE NUMBER:

TREATMENT TEAM MEMBERS:

Name Title Organization

Case Manager's phone number: _____

Describe the treatment program provided to the patient (what has been tried, what methods have been used):

Describe the result of that course of treatment (has there been any progress in treatment, has the patient maintained stability, have there been difficulties in providing effective treatment? Please be specific in describing the reason for your conclusions.):

Is an order of non-hospitalization still necessary to allow effective treatment? Why?

If this patient's condition was to decline, would the patient recognize this and/or request additional treatment needed to halt that decline?

Treatment Plan Coordinator: _____ Date: _____

Licensed Independent Practitioner: _____ Date: _____