|  |  |
| --- | --- |
| Name of Individual: | DOB: |
| DA: | Time/Date of Last Assessment: |
| Name of QMHP: |
| **SUPERVISION** | **TRANSPORT** |
| Emergency Department: | FROM: |
| TO: |
| Time and Date of Transport: |

*Pursuant to 18 V.S.A. §7511, secure transport and escort shall be done in a manner which prevents physical and psychological trauma, respects the privacy of the individual, and represents the least restrictive means necessary for the safety of the patient. It is the policy of the state of Vermont that mechanical restraints are not routinely used on persons who are receiving treatment involuntarily unless circumstances dictate that such methods are necessary.*

* Observation period prior to transportation decision may be used but should NEVER delay transport.
* Individual and/or family preference will be considered and accommodated, if possible, for mode of transport.

**Emergency Department Supervision is to be provided by DMH-contracted**

**providers or designees and is ordered exclusively by Admissions at VPCH 802-828-2799.**

**Considerations in Determining Mode of Transportation and Safety of Supervision:**

Individual’s history of behavior: ❑ cooperative ❑unwilling ❑ triggering ❑ unknown

|  |  |
| --- | --- |
| ❑ No ❑ Yes | Individual’s friends/family been consulted regarding service options? |
| ❑ No ❑ Yes | Individual been consulted regarding service options? |
| ❑ No ❑ Yes | Individual able to regulate his or her behavior? |
| ❑ No ❑ Yes | Individual approachable to discuss options? |
| ❑ No ❑ Yes | Any adverse events in last 24 hours? |
| ❑ No ❑ Yes | Individual’s mood seem stable and sustainable for the length of service ordered? |
| ❑ No ❑ Yes | **TRANSPORT ONLY**: If client was given PRN medication in the ED, have you discussed whether medical monitoring via ambulance would be necessary? |

|  |
| --- |
| Other supporting reasons for mode of transport or need for supervision:  Please reference form above. Be mindful of behavioral considerations for those who are transporting or supervising and do not know the individual.  Please provide any behavioral information that will enhance rapport building between the client and his/her transport team or supervision team in this box: |

**Signatures REQUIRED on back: OVER►**

|  |  |
| --- | --- |
| Name of Individual: | DOB: |
| DA: | Time/Date of Last Assessment: |
| Name of QMHP: |

**Mode of Transportation RECOMMENDED by QMHP or ATTENDING STAFF:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Vehicle |  | Accompaniment |  | Restraints |
| ❑ | Private transport | ❑ | friend/family | ❑ | None |
| ❑ | Mental health van alternative | ❑ | mental health staff | ❑ | Metal |
| ❑ | Unmarked alternative escort | ❑ | support specialist | ❑ | Soft |
| ❑ | Ambulance | ❑ | sheriff in vehicle |  |  |
| ❑ | Sheriff's cruiser | ❑ | Other: Peer, advocate etc. |  |  |
| ❑ | Sheriff’s van |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| ❑ | Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |

**Team Signatures**

|  |  |  |
| --- | --- | --- |
| Signature of QMHP or  Designated Professional  Please Print Name | Signature of Attending Physician/APRN  Please Print Name: | Signature of receiving transport specialist  Please Print Name: |
| Date and Time | Date and Time | Date and Time |

**Phone Number for QMHP or Designated Professional (REQUIRED): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*Signatures required if parties are involved in assessment of transport needs/outcomes*

► **Provide this form (both sides) to:**

* Transporter, supervision staff, or mental health transport specialist, *and*
* DMH, ATTN: Involuntary Transport or ATTN: Supervision, (fax 802-828-2749)

**Original will accompany emergency exam papers.**

**QMHP will keep a copy of this form for their records.**