



Certificate of Professional Initiating Involuntary Examination

ALL SECTIONS OF THIS FORM MUST BE COMPLETED AND LEGIBLE (PLEASE PRINT)

I have personally examined (printed name of individual) _____ at (time) _____ am pm

on (date) _____ in _____ County and said individual appears to meet criteria for involuntary examination (time noted must be within the preceding 48 hours).

This is to certify that my professional license number is: _____ and I am a licensed (check one box):

- Psychiatrist Physician (but not a Psychiatrist) Clinical Psychologist Psychiatric Nurse
- Clinical Social Worker Mental Health Counselor Marriage and Family Therapist Physician's Assistant

Section I: CRITERIA

1. There is reason to believe said individual has a mental illness as defined in section 394.455(28), Florida Statutes:

“Mental illness” means an impairment of the mental or emotional processes that exercise conscious control of one’s actions or of the ability to perceive or understand reality, which impairment substantially interferes with the person’s ability to meet the ordinary demands of living. For the purposes of this part, the term does not include a developmental disability as defined in chapter 393, F.S., intoxication, or conditions manifested only by antisocial behavior or substance use impairment.

Diagnosis of Mental Illness. List all mental health diagnoses applicable to this individual and the DSM/ICD codes:

AND because of the mental illness (check all that apply):

- a. Individual has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination; **OR**
- b. Individual is unable to determine for himself/herself whether examination is necessary; **AND**

2. Either (check all that apply):

- a. Without care or treatment said individual is likely to suffer from neglect or refuse to care for himself/herself, and such neglect or refusal poses a real and present threat of substantial harm to his/her well-being and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services; **OR**
- b. There is substantial likelihood that without care or treatment the individual will cause serious bodily harm to (check one or both) **self** **others** in the near future, as evidenced by recent behavior.

Section II: SUPPORTING EVIDENCE

Document observations supporting the criteria in Section I (including evidence of recent behaviors related to criteria). Include the individual’s behaviors and statements, including those specific to suicidal ideation, previous suicide attempts, homicidal ideation or self-injury. If school personnel are involved, please describe the nature of their involvement.

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Section III: OTHER INFORMATION

Identify other sources relied upon to reach this conclusion. If information is obtained from other persons, describe these sources (e.g., reports of family, friends, other mental health professionals or law enforcement officers, as well as medical or mental health records, etc.).

Section IV: INVOLUNTARY EXAMINATION FOR OUTPATIENT SERVICES ORDERS IN ACCORDANCE WITH SECTION 394.4655, F.S.

Complete this item ONLY if this involuntary examination is being initiated by a physician as defined by section 394.455(32), F.S. and, in your clinical judgment, the individual has failed or refused to comply with an involuntary outpatient services order.

For Section IV only, a personal examination within the preceding 48 hours is not required. In the box below, provide documentation of efforts to solicit compliance with the outpatient services treatment plan. The following efforts have been made to solicit compliance:

Section V: INFORMATION FOR LAW ENFORCEMENT

Provide identifying information (if known) if requested by law enforcement to find the individual so he/she may be taken into custody for examination:

Age: _____ Male Female Race/ethnicity: _____

Other details (such as height, weight, hair color, what wearing when last seen, where last seen):

If relevant, information such as access to weapon, recent violence or pending criminal charges:

This form must be transported with the individual to the receiving facility to be retained in the clinical record. Copies may be retained by the initiating professional and by the law enforcement agency transporting the individual to the receiving facility.

Section VI: SIGNATURE

			<input type="checkbox"/> am	<input type="checkbox"/> pm
Signature of Professional	Date Signed	Time		
Printed Name of Professional	Phone Number (including area code)			