CAUSE NO. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

THE STATE OF TEXAS FOR THE § IN THE \_\_\_\_\_\_\_\_\_ COURT OF

§

BEST INTEREST AND PROTECTION §

§

OF \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (initials only) § \_\_\_\_\_\_\_\_\_ COUNTY, TEXAS

**PHYSICIAN’S CERTIFICATE OF MEDICAL EXAMINATION FOR MENTAL ILLNESS**

I, the undersigned, a person licensed to practice medicine in the State of Texas, or a person employed by an agency of the United States having a license to practice medicine in any state of the United States, do hereby certify, to wit:

1. That my (***physician***) name and address, ***telephone, pager, cell numbers*** are:
2. That on the \_\_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_, 202\_\_, at the following location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, I evaluated and examined \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereafter called “***Proposed Patient***”.
3. Prior to this examination, the ***Proposed Patient***

( was

)

( ) was not

informed that communications with me would not be privileged.

1. The ***Proposed Patient***, whose address is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, has been under my care for the following, if any, period of time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.
2. A brief diagnosis of the physical and mental condition of the Proposed Patient on said date is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. An accurate description of the mental health treatment, if any, given by me or administered under my direction is as follows:
4. (NOTE: MUST BE COMPLETED IN EVERY CASE TO SHOW PATIENT IS A PERSPON WITH MENTAL ILLNESS AND MEETS THE CRITERIA FOR COURT-ORDERED MENTAL HEALTH SERVICES)

That I am of the opinion that the Proposed Patient is a person with mental illness, and that as a result of that illness the patient meets at least one of the following additional criteria (check the boxes of the criterion or criteria which apply to the Patient):

( is likely to cause serious harm to self;

)

( is likely to cause serious harm to others;

)

( is suffering severe and abnormal mental, emotional or physical distress; is experiencing substantial mental or physical deterioration of his ability to function independently, which is exhibited by the proposed patient’s inability, except for reasons of indigence, to provide for his basic needs, including food, clothing, health, or safety; and is unable to make a rational and informed decision as to whether or not to submit to treatment.

)

The ***detailed basis*** for this opinion is as follows:

A. On or about the above named person “***stated***” the following:

(Date)

1. “ ”

2. “ ”

3. “ ”

4. “ ”

B. On or about the above named person ***committed*** the following:

(Date)

1.

2.

3.

4.

That I am additionally of the opinion that the Patient’s condition is expected to continue for up to:

**Check one**: ( ) **45 Days** ( ) **90 Days**, the detailed basis for this opinion being:

1. (NOTE: COMPLETE THIS ITEM *ONLY* IF THIS CERTIFICATE IS TO BE OFFERED IN SUPPORT OF A MOTION FOR AN OPC. IT IS NOT SUFFICIENT TO RESPOND BY REFERENCE TO SAY ANY OTHER ITEM IN THIS CERTIFICATE.)

That I am further of the opinion that the Patient presents a substantial risk of serious harm to self or others if not immediately restrained, which is demonstrated by (check the box(es) as applicable):

( the person’s behavior; or

)

( by evidence of severe emotional distress and deterioration in his mental condition to the extent that the person cannot remain at liberty.

)

The ***detailed basis*** for this opinion is as follows:

A. On or about the above named person “***stated***” the following:

(Date)

1. “ ”

2. “ ”

3. “ ”

4. “ ”

B. On or about the above named person ***committed*** the following:

(Date)

1.

2.

3.

4.

1. (NOTE: COMPLETE THIS ITEM ***ONLY*** IF THIS CERTIFICATE IS TO BE OFFERED IN SUPPORT OF COURT-ORDERED EXTENDED MENTAL HEALTH SERVICES OR A RENEWAL OF SAME.)

That I am additionally of the opinion that the Patient’s condition, as set out in item 7, is expected to continue for **more than 90 days**, the detailed basis for this opinion being:

1. (NOTE: COMPLETE THIS ITEM ***ONLY*** IF THIS CERTIFICATE IS TO BE OFFERED IN SUPPORT OF COURT-ORDERED MENTAL HEALTH SERVICES FOR THE PATIENT UNDER A VOLUNTARY COMMITMENT WHO REFUSES TO CONSENT TO NECESSARY AND APPROPRIATE TREATMENT.)

The Patient is receiving voluntary inpatient services and has refused necessary and appropriate treatment, and in my opinion:

* 1. there is no reasonable alternative to the treatment recommended by the physician; **and**
  2. the patient will not benefit from continued inpatient care without the recommended treatment.

( ) **YES** ( ) **NO**

“My name is ; I am over the age of 21; (First) (Middle) (Last)

and my address is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

(street) (city) (state) (zip code)

I declare under penalty of perjury that the foregoing is true and correct.

Executed in \_\_\_\_\_\_\_\_ County, State of Texas, on the \_\_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_, 202\_\_.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Examining Physician