Secure

MENTAL HEALTH SCREENING FORM

Revised on 08/23/2021 for Adult

FORM MUST BE COMPLETED FULLY AND ELECTRONICALLY

I. IDENTIFYING DATA

Screen Urgency: **Tracking #:** **QMHP/LMHP:**

Location of Interview: **Contact Person:** **Contact Number:**

Screen Date (MM/DD/YYYY):

Start time: ☐ AM ☐ PM **Decision Time:** ☐ AM ☐ PM

Screening: Courtesy Screen ☐ Yes ☐ No **CMHC/HIS:**

Requested from: **Performed by:**

Name:_____
Last First MI

Pre-Marital Name: **Also Known As (AKA):**

Street Address:

Street Address:

City, State, ZIP:

Phone:

Unique ID#:

SSN:

Veteran: ☐ Yes ☐ No ☐ Unknown

DOB (MM/DD/YYYY)**:** **Age:**

Sex at birth: ☐ M ☐ F **Pronouns:**

Race:

County/Residence:

County/Responsibility:

Current outpatient treatment order:
☐ Yes ☐ No ☐ Unknown

Referred by:

Consumer status:
☐ Current CMHC Consumer
☐ Former CMHC Consumer
☐ Other CMHC Consumer
☐ Never a CMHC Consumer
☐ Private Provider Consumer

Screening Informant(s)
☐ Self
☐ Family/Significant other
☐ CMHC/Private Provider
☐ Hospital/Inpatient/Residential Staff
☐ DCF Contact
☐ DOC Contact
☐ LEO (Law Enforcement Officer)
☐ Other: _____

Custody Status
☐ Parental ☐ DCF ☐ DOC
☐ Guardian ☐ None

Screening Completed for State Hospital/SIA (State Institution Alternative):
☐ Yes ☐ No

Other community options (not including SIAs) have been exhausted:
☐ Yes ☐ No

Facility 1 Denial (name, NOT SIA beds):

Facility 2 Denial (name, NOT SIA beds):

II. SUPPORT SYSTEMS Guardian: ☐ Yes ☐ No ***Name/phone#***:

If yes, Guardianship letter/documentation: ☐ Yes ☐ No

This individual has others involved in a helpful way (check):

☐Parent ☐Family ☐Friends ☐Case Worker ☐Neighbor ☐N/A ☐Other
Name/address/phone#:
Name/address/phone#:

This individual has: ☐ Adequate support systems ☐ Limited support system ☐ No support systems
☐ Stable living environment ☐ Receiving HCBS Waiver services ☐ Homeless
☐ Currently incarcerated ☐ Living independently

Explain:

FINANCIAL RESOURCES: ☐ **Employed** ☐ **Unemployed** ☐ **Other:**

Pending Medicaid: ☐ Medicaid ID #: Medicare ID #:

Other ID/Insurance: Uninsured ☐

III. PRESENTING PROBLEM(S) – CHECK ALL THAT APPLY

☐ Current Danger to SELF ☐ Potential Danger to SELF ☐ Self Care Failure ☐ Substance Abuse
☐ Current Danger to OTHERS ☐ Potential Danger to OTHERS ☐ Psychotic Symptoms ☐ Suicidal/Homicidal
☐ Current Danger to PROPERTY ☐ Potential Danger to PROPERTY ☐ Mood Disorder ☐ Other

Explain concerns in detail:

IV. RISK FACTORS

Current Danger to Self:

☐ ***None*** ☐ Ideation ☐ Plan ☐ Threat ☐ Intent with means ☐ Intent w/o means ☐ Self-care failure
☐ Gesture/attempt ☐ Risk aggravated by substance use ☐ Able to participate in safety planning ☐ N/A

Explain (Include dates, means, rescue):

History of Danger to Self:
☐ ***None*** ☐ Ideation ☐ Plan ☐ Threat ☐ Intent with means ☐ Intent w/o means
☐ Self-care failure ☐ Gestures/attempts ☐ Risk aggravated by substance use
☐ Able to participate in safety planning ☐N/A

Explain (Include dates, means, rescue)

Current Danger to Others: ☐ ***None*** ☐ Ideation ☐ Plan ☐ Threat ☐ Intent with means ☐ Intent w/o means
☐ Gesture/attempt ☐ Risk aggravated by substance use ☐ Able to participate in safety planning ☐ N/A

Explain (Include dates, means, rescue)

History of Danger to Others: ☐ ***None*** ☐ Ideation ☐ Plan ☐ Threat ☐ Intent with means ☐ Intent w/o means
☐ Gesture/attempt ☐ Risk aggravated by substance use ☐ Able to participate in safety planning ☐ N/A

Explain (Include dates, means, rescue)

Current Destruction of Property: ☐ YES ☐ NO ☐ Unknown ☐N/A
History of Destruction of Property: ☐YES ☐ NO ☐ Unknown ☐N/A

Explain:

History of family or someone close attempting or completing suicide: ☐ ***No*** ☐ Yes ☐ Unknown

Explain:

Current Abuse: ☐YES ☐ NO ☐ UNKNOWN
TYPES: ☐ Physical ☐ Sexual ☐ Emotional ☐ Neglect ☐ History reported
If yes, individual is: ☐ Victim ☐ Perpetrator ☐ Both ☐ Neither, but abuse reported in environment

Explain:

Gambling Addiction: ☐ Past ☐Current ☐Unknown Internet Addiction: ☐ Past ☐Current ☐Unknown

Substance Use: Indication of substance related issues: ☐ Yes ☐ No ☐ Unknown
☐ Positive lab screen for:

DRUGS OF CHOICE	**Primary Drug**	**Secondary Drug**	**Tertiary Drug**
Name of Drug			
Currently Using	☐ YES ☐ NO ☐ Unknown	☐ YES ☐ NO ☐ Unknown	☐ YES ☐ NO ☐ Unknown
Past Use	☐ YES ☐ NO ☐ Unknown	☐ YES ☐ NO ☐ Unknown	☐ YES ☐ NO ☐ Unknown
Frequency	☐ Unknown ☐	☐ Unknown ☐N/A	☐ Unknown ☐N/A
Amount	☐ Unknown ☐N/A	☐N/A ☐ Unknown	☐ Unknown ☐N/A
Last date of use	☐ Unknown ☐N/A	☐ Unknown ☐N/A	☐ Unknown ☐N/A

Complications related to detoxification/withdrawal (seizures, etc.): ☐N/A

Substance Abuse Treatment: ☐ None ☐ Detox ☐ Outpatient ☐ Inpatient ☐ Oxford House/similar ☐ Unknown ☐N/A

Explain (Include current/ history, legal history)

Medical Concerns: ☐ None reported ☐ Self/family report ☐ Primary Care Physician report ☐ Medical records ☐ NKDA ☐ Drug allergies:

Explain (Include current/ history of medical concerns):

List ALL Current Medications: Specify Name & Dosage

Taking as directed: (Y) Yes (N) No (U) Unknown

		Y	N	U			Y	N	U
Medication:	Dosage: Last Dosage taken:	☐	☐	☐	Medication:	Dosage: Last Dosage taken:	☐	☐	☐
		Date:					Date:		
Medication:	Dosage: Last Dosage taken:	☐	☐	☐	Medication:	Dosage: Last Dosage taken:	☐	☐	☐
		Date:					Date:		
Medication:	Dosage: Last Dosage taken:	☐	☐	☐	Medication:	Dosage: Last Dosage taken:	☐	☐	☐
		Date:					Date:		
Medication:	Dosage: Last Dosage taken:	☐	☐	☐	Medication:	Dosage: Last Dosage taken:	☐	☐	☐
		Date:					Date:		
Medication:	Dosage: Last Dosage taken:	☐	☐	☐	Medication:	Dosage: Last Dosage taken:	☐	☐	☐
		Date:					Date:		
Medication:	Dosage: Last Dosage taken:	☐	☐	☐	Medication:	Dosage: Last Dosage taken:	☐	☐	☐
		Date:					Date:		

Psychiatrist/Location: ☐ Unknown

Primary Care Physician/Location: ☐ Unknown

Please put an X in the box as applicable on each line ***(Y) Yes (N) No (U) Unknown (N/A) not applicable***

	Y	N	U	N/A		Y	N	U	N/A
Patient requires O2	☐	☐	☐	☐	Patient requires other durable medical equipment. *If yes, explain below in Medical Q4*	☐	☐	☐	☐
If yes, will the patient be coming with O2?	☐	☐	☐	☐	**Patient will bring equipment if admitted?**	☐	☐	☐	☐
Patient has a urinary catheter	☐	☐	☐	☐	Patient able to perform ADLS? *If No, use Medical Q5*	☐	☐	☐	☐
If yes, will it be removed?	☐	☐	☐	☐	Patient ambulatory on their own. *If No, provide details below in Medical Q6.*	☐	☐	☐	☐
IV or Central Line	☐	☐	☐	☐	Patient has a history of multi-drug resistant organism (MRSA, etc.)	☐	☐	☐	☐
If Yes, will it be removed?	☐	☐	☐	☐	Patient is confined to a bed	☐	☐	☐	☐
Patient is on Dialysis. *If yes, provide details below use Medical Q1*	☐	☐	☐	☐	Patient requires 1:1 staff at their current placement	☐	☐	☐	☐
Patient requires a ventilator. *If yes, provide details below use Medical Q2*	☐	☐	☐	☐	Patient has an open wound. *If yes, provide details below in Medical Q7*	☐	☐	☐	☐
Patient requires a CPAP. *If yes, provide details below in Medical Q3*	☐	☐	☐	☐	Patient has allergies. *If yes, provide details below use Medical Q8*	☐	☐	☐	☐
If yes, patient will be coming with equipment?	☐	☐	☐	☐					

Explanations by question for the above table:

Medical Q1 Dialysis details:
Medical Q2 Ventilator details:
Medical Q3 CPAP details:
Medical Q4 Medical equipment details:
Medical Q5 ADL barrier details:
Medical Q6 Ambulatory details:
Medical Q7 Open wound details:
Medical Q8 Allergy details:

V. CLINICAL IMPRESSIONS

General Appearance
- ☐ Appropriate hygiene/dress
- ☐ Poor personal hygiene
- ☐ Overweight
- ☐ Underweight
- ☐ Eccentric ☐ Seductive

Sensory/Physical Limitations
- ☐ No limitations noted
- ☐ Hearing ☐ Visual
- ☐ Physical ☐ Speech

Mood
- ☐ Cooperative ☐ Calm
- ☐ Cheerful ☐ Anxious
- ☐ Depressed ☐ Fearful
- ☐ Suspicious ☐ Labile
- ☐ Tearful ☐ Pessimistic
- ☐ Euphoric ☐ Irritable
- ☐ Guilty ☐ Hostile
- ☐ Dramatized ☐ Apathetic
- ☐ Elevated mood
- ☐ Marked mood shifts

Affect
- ☐ Primarily appropriate
- ☐ Primarily inappropriate
- ☐ Restricted ☐ Blunted
- ☐ Flat ☐ Detached

Speech
- ☐ **Unable to assess**
- ☐ Logical/Coherent ☐ Loud
- ☐ Delayed responses
- ☐ Tangential
- ☐ Rambling ☐ Slurred
- ☐ Rapid/Pressured
- ☐ Incoherent/loose associations
- ☐ Soft/Mumbled/Inaudible

Thought Content/Perceptions
- ☐ ***Unable to assess***
- ☐ Delusions
- ☐ No disorder noted
- ☐ Grandiose ☐ Paranoid
- ☐ Racing ☐ Circumstantial
- ☐ Obsessive ☐ Disorganized
- ☐ Flight of ideas ☐ Bizarre
- ☐ Blocking
- ☐ Auditory Hallucinations
- ☐ Visual Hallucinations
- ☐ Other hallucinatory activity
- ☐ Ideas of reference
- ☐ Illusions/Perceptual distortions
- ☐ Depersonalization or Derealization

Memory
- ☐ ***Unable to assess-***
- ☐ No impairment noted
- ☐ Impaired ☐ remote ☐ recent

Insight (Age Appropriate)
- ☐ ***Unable to assess-***
- ☐ Good ☐ Fair ☐ Poor
- ☐ Lacking

Orientation
- ☐ ***Unable to assess***
- ☐ Impaired time ☐ Oriented x 4
- ☐ Impaired person
- ☐ Impaired place
- ☐ Impaired situation

Cognition/Attention
- ☐ ***Unable to assess***
- ☐ No impairment noted
- ☐ Distractibility/Poor concentration
- ☐ Impaired abstract thinking
- ☐ Impaired judgment
- ☐ Indecisiveness

Behavior/Motor Activity
- ☐ ***Unable to assess***
- ☐ Normal/Alert ☐ Poor eye contact
- ☐ Self-Destructive
- ☐ Uncoordinated ☐ Lethargic
- ☐ Catatonic ☐ Repetitious
- ☐ Tense ☐ Agitated
- ☐ Withdrawn ☐ Tremors/Tics
- ☐ Aggression/Rage
- ☐ Restless/Overactive
- ☐ Peculiar mannerisms
- ☐ Bizarre behavior
- ☐ Impulsiveness ☐ Compulsive
- ☐ Indiscriminate socializing
- ☐ Disorganized behavior
- ☐ Feigning of symptoms
- ☐ Avoidance behavior
- ☐ Increase in social, occupational, sexual activity
- ☐ Decrease in energy, fatigue
- ☐ Loss of interest in activities

Eating/Sleep Disturbance
- ☐ ***Unable to assess*** No disturbance noted
- ☐ Increased appetite
- ☐ Decreased appetite
- ☐ Binge eating
- ☐ Weight ☐ Gain/ ☐ Loss (lbs/time)
- ☐ Self-induced vomiting
- ☐ Sleep
- ☐ Bed-wetting
- ☐ Nightmares/Night Terrors

Anxiety Symptoms
- ☐ ***Unable to assess***
- ☐ Within normal limits
- ☐ Generalized anxiety
- ☐ Fear of social situations
- ☐ Panic attacks
- ☐ Obsessions/Compulsions
- ☐ Hyper-vigilance
- ☐ Reliving traumatic events

Conduct Disturbance
- ☐ **Unable to assess**
- ☐ Conduct appropriate
- ☐ Stealing ☐ Lying
- ☐ Projects blame ☐ Fire setting
- ☐ Short-tempered
- ☐ Defiant/Uncooperative
- ☐ Violent behavior
- ☐ Cruelty to animals/people
- ☐ Running away ☐ Truancy
- ☐ Criminal activity ☐ Vindictive
- ☐ Argumentative
- ☐ Antisocial behavior
- ☐ Destructive to others or property

Occupational & School Impairment
- ☐ **Unable to assess**
- ☐ No impairment noted
- ☐ Impairment grossly in excess than expected in physical finding
- ☐ Impairment in occupational functioning
- ☐ Impairment in academic functioning
- ☐ Not attending school/work

Interpersonal/Social Characteristics
- ☐ ***Unable to assess***
- ☐ No significant trait noted
- ☐ Chooses relationships that lead to disappointment
- ☐ Expects to be exploited or harmed by others
- ☐ Indifferent to feelings of others
- ☐ Interpersonal explosiveness
- ☐ No close friends or confidants
- ☐ Unstable and intense relationships
- ☐ Excessive devotion to work
- ☐ Inability to sustain consistent work behavior
- ☐ Perfectionistic ☐ Grandiose
- ☐ Procrastinates ☐ Entitlement
- ☐ Persistent emptiness & boredom
- ☐ Constantly seeking praise or admiration
- ☐ Excessively self-centered.
- ☐ Avoids significant interpersonal contacts
- ☐ Manipulative/Charming/Cunning

NOTES:

Self-induced vomiting

VI. TREATMENT/PLACEMENT INFORMATION
(history for both adult and for youth history and current)

Currently in treatment: ☐ Yes ☐ No ☐ Unknown Therapist: Case Manager:

Agency/Provider/Service(s)

Service Progress/Failures(s)

Previously Hospitalized: ☐ Yes ☐ No ☐ Unknown Multiple Hospitalizations: ☐ Yes # of: ☐ No

☐ Unknow

Last psychiatric hospitalization: Facility Date Admitted Date Dismissed ☐AMA

History in Corrections system and/or as juvenile offender: ☐ Yes ☐ No ☐ Unknown

Explain:

Charges Pending: ☐Yes ☐ No ☐ Unknown

Explain:

Determined by court to be: ☐ CINC ☐ JO ☐ N/A ☐ Other

Explain:

Placement/Admission History (mark all the apply):

☐ Detention ☐ Foster Care
☐ Psychiatric Residential Treatment Facility
☐ QRTP ☐ YRC ☐ Secure Care
☐ Nursing Facility for Mental Health ☐ State Hospital/SIA
☐ Private Psychiatric Hospital ☐ Other:

Comments:

Name of School Highest Grade Completed ☐ Unknown

Educational Concerns and current supports (e.g. IEP, GED, LD)

VII. CLINICAL SUMMARY AND DIAGNOSTIC IMPRESSIONS

MEETS CRITERIAL FOR: : ☐ SED ☐ SPMI ☐ UNKNOWN ☐ N/A

DIAGNOSES:

***NARRATIVE*:** (any additional information that has not been covered by the prior information**)**

COMPLETE FOR INPATIENT PSYCHIATRIC

VIII. INPATIENT CRITERIA

Level 1, Independent: Criteria which, in and of themselves, MAY constitute justification for admission.

☐ 1. Suicide attempt, threats, gestures indicating potential danger to self.
☐ 2. Homicidal threats or other assaultive behavior indicating potential danger to others.
☐ 3. Extreme acting out behavior indicating danger or potential danger to property.
☐ 4. Self-care failure indicating an inability to manage daily basic needs that may cause self-injury.

Level 2, Dependent: Clinical characteristics of psychiatric disorders, any of which in combination with at least ONE
Level 3 criterion, MAY constitute justification for admission.

☐ 5. Clinical depression.
☐ 6. Intense anxiety or panic that may cause injury to self or others.
☐ 7. Loss of reality testing with bizarre thought processes such as paranoia, ideas of reference, etc.
☐ 8. Impaired memory, orientation, judgment, incoherence or confusion.
☐ 9. Impaired thinking and/or affect accompanied by auditory or visual hallucinations.
☐ 10. Mania or Hypomania.
☐ 11. Mutism or catatonia.
☐ 12. Somatoform disorders.
☐ 13. Severe eating disorders such as bulimia or anorexia.
☐ 14. Severely impaired social, familial, academic, or occupational functioning, which may include excessive use of substances.
☐ 15. Severe maladaptive or destructive behaviors in school, home or placement, which may include excessive use of substances.
☐ 16. Extremely impulsive and demonstrates limited ability to delay gratification.

Level 3, Contingent: Acute-care program needs which MAY justify psychiatric hospital admission.

☐ 17. Need for medication evaluation or adjustment under close medical observation.
☐ 18. Need for 24-hour structured environment due to inability to maintain treatment goals or stabilize in less intensive levels of care.
☐ 19. Need for continuous secure setting with skilled observation and supervision
☐ 20. Need for 24-hour structured therapeutic milieu to implement treatment

DISPOSITION/REIMBURSEMENT AUTHORIZATION

☐ (A.) Meets inpatient criteria. State Hospitalization recommended. ☐ Voluntary ☐ Involuntary

Admitted/transferred/referred to hospital Admission Date

Treatment Expectations/Preliminary Discharge Plan:

☐ (B) Meets inpatient criteria, but not state hospital admission. ☐Copy given to legally responsible individual.

Explain instructions provided to the patient:

☐ (C) Does not meet inpatient criteria. Outpatient community services plan recommended.

☐ Copy given to legally responsible individual. Explain instructions provided to the patient:

I certify that local community resources have been investigated and/or consulted to determine whether or not any of them can furnish appropriate and necessary care. I have seen this individual and have evaluated him/her and his/her situation. I have also considered alternate modes of treatment. All community resources have been investigated and are not available if hospitalization is recommended.

IX. TIME DOCUMENTATION SUMMARY

Contact /Activity	**Amount of Time**
☐ Chart Review:	_____
☐ Paperwork:	_____
☐ Face-to-Face Interview:	_____
☐ Collateral Contacts/Coordination:	_____
☐ Consultation/Team Meetings:	_____

Total Screen Time: _____ **Hours** _____ **Minutes**

Travel Time To/From: _____ **Hours** _____ **Minutes**

Total Time: _____ **Hours** _____ **Minutes**

_____

Signature of Qualified Mental Health Professional designated as a member of MHC Screening Team Date

COMPLETE FOR STATE HOSPITAL

X. SCREENING DISPOSITION

☐ Not in need of Inpatient psychiatric treatment.

☐ Community-based plan when State Hospital Admission is not recommended; copy given to legally responsible

individual.

☐ Recommended voluntary admission to State Hospital.

☐ Recommended involuntary outpatient commitment to .

☐ Recommended involuntary admission to State Hospital in accordance with KSA Statute;

(Must meet criteria 1, 2, and 3, plus 4 and/or 5 below)

☐ 1. Is suffering from a severe mental disorder to the extent that he/she needs involuntary care in a State Hospital.

☐ 2. Lacks the capacity to make an informed decision concerning his/her need for treatment.

☐ 3. Is not manifesting a primary diagnosis of antisocial personality disorder, chemical abuse/addiction, mental retardation organic personality syndrome, or an organic mental disorder.

☐ 4. Is likely, in the reasonably foreseeable future, to cause substantial physical injury or physical abuse to self or others or substantial damage to another's property, as evidenced by behavior causing, attempting, or threatening such injury, abuse or damage; **OR**

☐ 5. Is substantially unable, except for a reason of indigence, to provide for any of his/her basic needs, such as food, clothing, shelter, health, or safety, causing a substantial deterioration of the person's ability to function with current level of support, care or structure

Please note for children under 18, admission to a state hospital must be by

1.) Voluntary application for a child age 14 or over.
2.) Voluntary application by a parent.
3.) Voluntary application by legal guardian or by DCF if parental rights have been severe (with appropriate court authority, see KSA 59-3018a).
4.) Involuntary civil commitment.

Treatment Expectations/Preliminary Discharge Plan:

Comments:

XI. TIME DOCUMENTATION SUMMARY

Contact /Activity	**Amount of Time**
☐ Chart Review:	_____
☐ Paperwork	_____
☐ Face-to-Face Interview:	_____
☐ Collateral Contacts/Coordination:	_____
☐ Consultation/Team Meetings:	_____

Total Screen Time: _____ **Hours** _____ **Minutes**

Travel Time To/From: _____ **Hours** _____ **Minutes**

Total Time: _____ **Hours** _____ **Minutes**

I certify that local community resources have been investigated and/or consulted to determine whether or not any of them can furnish appropriate and necessary care. I have seen this individual and have evaluated him/her and his/her situation. I have also considered alternate modes of treatment. All community resources have been investigated and are not available if hospitalization is recommended.

_____

Signature of Qualified Mental Health Professional designated as a member of MHC Screening Team Date Time

COMMUNITY SERVICES PLAN

Alternative plan will include the following existing community resources:

	Resource	Date	Time	Provider/Facility
☐	Emergency Services			
	☐ Crisis Intervention			
	☐ Crisis Appointment			
	☐ Crisis Attendant Care			
	☐ Crisis Case Management			
	☐ Crisis Resolution			
☐	Outpatient Services/testing/evaluation			
☐	Individual Therapy			
☐	Family therapy			
☐	In-home family therapy			
☐	Mental Health Targeted Case Management			
☐	Community Psychiatric Supportive Treatment			
☐	Attendant Care			
☐	Respite Care			
☐	Psychosocial Rehabilitation			
☐	Supportive educational/vocational program			
☐	Residential group home			
☐	Therapeutic foster care			
☐	Professional resource family			
☐	Nursing facility/mental health bed			
☐	Local/area inpatient psychiatric unit			
☐	Outpatient substance abuse services			
☐	Social detox/Inpatient substance abuse			
☐	Immediate medical/medication evaluation			
☐	Refer for co-occurring disorder evaluation			
	☐ MH/IDD			
	☐ MH/Substance Abuse			
☐	Psychiatric Residential Treatment			
☐	Other			
☐	SED Waiver Services			

Community/Safety Plan: Specify plan for involving natural or other support systems. Include provider address/phone #s.

Signature below indicates that I have reviewed and received a copy of this plan.

Consumer/Legally Responsible Individual **Date:**

QMHP/LMHP **Date** **Time** **Collateral** **Date:**

ADDITIONAL NOTES:

STATEMENT FROM A QUALIFIED MENTAL HEALTH PROFESSIONAL AUTHORIZING ADMISSION TO A KANSAS STATE PSYCHIATRIC HOSPITAL

RE: _____

(name of patient) (DOB) (age) (sex)

_____

(patient's address) (city, state, zip) (county)

Based upon my screening of the above named person, done by me in person and/or by review of this person's records and of reports concerning this person, and being familiar with the resources and services which are available within this community, I find that the needs of this person for the services indicated below cannot be adequately met in this community, and I therefore authorize that the following service(s) be provided at a state psychiatric hospital.

CHECK ONLY EACH TYPE OF SERVICE AUTHORIZED:

A. ☐ **VOLUNTARY** care and treatment (which this person has indicated to me that he/she wishes to be admitted for and which I believe he/she has the capacity to consent to (See KSA 59-2949(a)).

B. **INVOLUNTARY** care and treatment as specified below:

☐ EMERGENCY or TEMPORARY DETENTION AND TREATMENT pursuant to KSA 59-2954, or under the Court's EX PARTE EMERGENCY CUSTODY ORDER (see KSA 59-2958), or under the Court's TEMPORARY CUSTODY ORDER (see KSA 59-2959) if either are issued.

☐ MENTAL EVALUATION, including the examination(s) necessary to prepare the report to be submitted to the Court to assist in the trial of the issue of whether or not this person is a mentally ill person subject to involuntary commitment (see KSA 59-2961).

☐ INPATIENT CARE AND TREATMENT as may be ordered by the Court in any ORDER of CONTINUANCE AND REFERRAL (see KSA 59-2964) or ORDER FOR TREATMENT (see KSA 59-2966), or ORDER FOR CONTINUED TREATMENT (see KSA 59-2969(f)).

_____

(Date) (Signature of QMHP)

913-268-0156 11120 W 65th St, Shawnee, KS 66203

(Telephone No.) (CMHC address)

☑ Original to be filed with the Court (if involuntary proceedings)

☑ Copy to_____State Hospital

☐ Copy to_____CMHC (if courtesy screen)

EMERGENCY ROOM/HOSPITAL TRANSFERS: If the patient has been taken to any emergency room of any community hospital, or is currently admitted to any inpatient department at any community hospital, medical consultations must have been completed prior to any transfer of the patient to any state psychiatric hospital and the treating physician at the community hospital and the physician on duty at the state hospital must concur that the patient is medically stable and that the state hospital is capable of managing the patient's physical condition (See 42U.S.C. Sec. 1395dd). List below (1) the name of the local treating/emergency room physician and (2) the name of the physician on duty at the state hospital who has agreed to accept the transfer:

(1) _____ (2) _____

CERTIFICATE OF A PHYSICIAN, LICENSED PSYCHOLOGIST, OR A DESIGNATED QUALIFIED MENTAL HEALTH PROFESSIONAL
(to be attached to a Petition to Determine a Person to be a Mentally Ill Person Subject to Involuntary Commitment)

RE: _____
(name of patient)

_____
(patient's address) (city, state, zip)

I certify that:

☑ I am a ☐ licensed physician; ☐ licensed psychologist; ☑ qualified mental health professional designated by the head of a mental health center to make this certificate;

☐ I have on_____(date) personally examined the above named patient and reviewed any available records, and on the basis thereof:

☐ It is my professional opinion that the patient is likely to be a mentally ill person subject to involuntary commitment for care and treatment as that term is defined in KSA 59-2946 (f), including that this patient:

(☐) is suffering from a mental disorder to the extent the person is in need of treatment;

(☐) lacks the capacity to make an informed decision concerning treatment, despite conscientious efforts at explanation or efforts to elicit a response from the patient showing an ability to engage in a rational decision-making process;

(☐) is likely to cause harm to self or others or substantial damage to property of another;

(☐) is not solely diagnosed with one of the following mental disorders: alcohol or chemical substance abuse; anti-social personality disorder; mental retardation; organic personality syndrome; or an organic mental disorder.

NOTE: all four of the above described conditions must be applicable to this person in order for the patient to meet the legal definition of a mentally ill person subject to involuntary commitment.

☐ (OPTIONAL) For this reason, I recommend that the patient be detained and admitted to an appropriate inpatient treatment facility for further observation and treatment pending Court proceedings.

_____ X_____
(date) (Signature of physician, psychologist, QMHP)

913-268-0156 JCMHC
(bus. Telephone no.) (name of facility, mental health center or clinic associated with)

_____
(business address) (city, state, zip)

☐ mental health center screening form attached
☐ other medical record or statement attached
☐ copy to _____
☐ copy to _____

Osawatomie STATE HOSPITAL

APPLICATION FOR EMERGENCY ADMISSION (FOR OBSERVATION AND TREATMENT)

Purusant to KSA 59-2954 (b) or (c)

Patient: _____ _____ _____

(name) (DOB) (sex)

_____ _____

(home address) (SSN)

_____ _____

(city, state, zip) (county of residence)

_____ _____

(name of spouse or nearest relative) (telephone no.)

_____

(address, if different from the patient's)

I request admission of the above named person for emergency observation and treatment upon the following circumstances:

(1) ☐ I am **a law enforcement officer** having custody of this person pursuant to the provisions of KSA 59-2953, and:

☐ I will file a petition seeking the involuntary commitment of this person with the District Court of _____ County, not later than the close of business on_____(date), or;

☐ I have been informed by _____that s/he will file such a petition. This individual may be contacted at:_____.

(2) ☐ I am **not** a law enforcement officer, but I am familiar with the circumstances of this patient immediately preceding this application, and I will file a petition seeking the involuntary commitment of the patient with the District Court of _____County, not later than the close of business on_____(date).

(3) ☐ I believe this patient to be a mentally ill person subject to involuntary commitment for care and treatment (as defined in KSA 59-2946(f) and is likely to cause harm to self or others if not immediately detained. In support thereof I state that:

(4) ☐ The following criminal charges are known by me to be pending against this patient:

☐ None ☐ It is unknown by me whether any charges are pending against this person.

(5) ☐ Because this application is for admission to a state psychiatric hospital, the required statement from a qualified mental health professional is attached, having been obtained at the_____Community Mental Health Center.

(6) ☐ Other documentation, medical records or reports concerning this patient are attached.

(7) ☐ Other documentation, medical records or reports concerning this patient may be found and consulted at:

_____ X_____

(date) (signature)

_____ _____

(time) (printed name) (L.E.O. badge #)

_____

(address)

913-268-0156 _____

(telephone no.) (city, state, zip)