CERTIFICATE OF AN EXAMINING PROFESSIONAL REGARDING INVOLUNTARY ADMISSION FOR CARE AND TREATMENT

Osawatomie State Hospital
Osawatomie, KS 66064-0500

Re: _____
(name of patient)

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

I certify that:

I am a ☐ licensed physician; ☐ licensed psychologist; ☐ state certified alcohol and substance abuse counselor employed at a state funded and designated assessment center;

☐ On _____ (date), I personally examined the above named patient and/or reviewed any available records, and on the basis thereof:

☐ It is my professional opinion that this patient is likely to be a person with an alcohol or substance abuse problem subject to involuntary commitment for care and treatment as that term is defined in KSA 59-29b46(g), including that this patient:
(Check all appropriate criteria)

- ☐ **lacks self control** as to the use of alcohol beverages or any substance defined in KSA 59-29b46;
- ☐ **is incapacitated,** in that as a result of the use of alcohol or any substance defined in KSA 59-29b46(k), the person has impaired judgment resulting in the person:
  (select as appropriate)
  - ☐ being incapable of realizing and making a rational decision with respect to the need for treatment; or
  - ☐ lacking sufficient understanding or the capability to make or communicate responsible decisions concerning either the person's well-being or their estate;
- ☐ **is likely to cause harm** to self or others or substantial damage to the property of another.

NOTE: all <u>three</u> of the above described conditions must be applicable to this person in order for the patient to meet the legal definition of a person with an alcohol or substance abuse problem 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.

_____ _____
(date) (signature of physician, psychologist, SCA/SAC)

_____ _____
(bus. telephone #) (name of facility, clinic or assessment center associated with)

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

☐ screening assessment form attached
☐ other patient medical records or statement(s) attached