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 _____

Revised September 2012