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 **Brevard** 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: ME174584 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 Assistant ☐ Advanced Practice Registered Nurse under s. 464.0123 F.S.

Section I: CRITERIA

1. There is reason to believe said individual has a mental illness as defined in section 394.455, 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, intoxication, or conditions manifested only by dementia, traumatic brain injury, antisocial behavior, or substance abuse.

Diagnosis of Mental Illness is: List all mental health diagnoses applicable to this individual & DSM/ICD Codes: ☐☐☐☐☐☐

Depression F32.9

Suicidal Thoughts R45.851

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, describe the nature of their involvement.

Patient reports thoughts of ending their life

Section III: OTHER INFORMATION

Other information, including source relied upon to reach this conclusion is as follows. 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 394.4655, F.S.

Complete this item ONLY if this involuntary examination is being initiated by a physician as defined by section 394.455(33), 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 person to the receiving facility.

Section VI: SIGNATURE

_____ _____ _____ ☐ am ☐ pm

Signature of Professional | Date Signed | Time

Mackenzie Link, MD _____

Printed Name of Professional | Phone Number (including area code)

CF-MH 3052b, (July 2023) [65E-5.280, F.A.C.]