DELAWARE HEALTH AND SOCIAL SERVICES
Division of Substance Abuse and Mental Health
1901 North DuPont Highway, New Castle, Delaware 19720
Eligibility & Enrollment Unit 302.255.9458

PSYCHIATRISTS' CERTIFICATE FOR PROVISIONAL HOSPITALIZATION* (Civil Commitment)

Fax copy of completed form to DSAMH Eligibility and Enrollment Unit during business hours, Mon.-Fri., 7 a.m.-3 p.m. to 302.255.4416 or outside business hours, to 302.255.9952

REVIEWING PSYCHIATRIST: *Please complete EITHER the Admission or the Discharge Statement, attach documentation and sign the bottom of the form.*

CERTIFICATE for PROVISIONAL HOSPITAL ADMISSION *(to be completed for persons being referred for inpatient evaluation).*

I certify that on ________________, ___________ a.m. / p.m. at ____
Date (mm/dd/yy) Time (00:00) Location

I have carefully examined ____ ____________________
Name Date of Birth (mm/dd/yyyy)

of ________________________________ ________________ ________ ________
Street Address City State Zip

and corroborate the certified Mental Health Screener's finding him/ her to have met the standard for mental illness as well as dangerousness to self or others, therefore requiring involuntary provisional admission and immediate care or treatment.

I offered this person voluntary in-patient treatment and

- ☐ this person is unable to self-determine need for treatment.
- ☐ this person refused voluntary treatment.

Based on above, ☐ I have begun the involuntary commitment process as set forth in Title 16, Chapter 50 of the Delaware Code by recommending involuntary provisional admission.

This person ☐ is ☐ is not capable of waiving procedural rights, including retention of

- ☐ counsel,
- ☐ psychiatrist or
- ☐ **other qualified medical expert** to testify on his/her behalf at the court hearing.

(If financial assistance is required to retain counsel or other expert, please complete certification of financial need on page 2)

The required request for court hearing ☐ has ☐ has not been filed as required within 48 hours of provisional admission.

I offered this person voluntary in-patient treatment and

☐ this person has accepted a voluntary offer of in-patient treatment and

__________ I certify that this is the least restrictive, most appropriate level of care given this person's symptoms.
Initial

NOTIFICATION OF RIGHTS

__________ I certify that I have this day delivered to the above-named client a copy of 16 Del. C., Sec 5161, "Rights of Patients in Hospitals for the Mentally Ill," and other rights set forth in Title 16.
Initial

I acknowledge that I have received this information. ____
Signature of Client Date Time

☐ This person refused to sign acknowledgment.

(*Pursuant to Del. Code Title 16 §5003. Request for Court Hearing to be filed within 48 hours. Del.Code Title 16 §5007)

I have personally and carefully conducted a psychiatric examination of this client. The behaviors and symptoms I observed are described below.(summarize attached behavior observations and examination findings observed):

I considered and discussed with this client less restrictive, community-based treatment options noted below, which were subsequently ruled out for the reasons noted.

(if person is to be transported) **I have notified the nearest known relative**____

Name and Relationship

that the person is being taken to:____

Facility Name and Location

(Please document below and/or attach other forms or documents as needed to support your findings)

Del. Administrative Code, Title 16, Reg 6002, Sec. 6.1 Conflict of Interest Statement: The intent of the law is to ensure that no person is detained for any reason other than experiencing symptoms associated with a mental condition that may result in danger to self or others, and that any conflicts of interest as set forth in 16 Del.C. §5122 are disclosed on the DSAMH Crisis Intervention Assessment Tool and 24-hour Emergency Admission form filed with DSAMH within 24 hours of signature of the detention order. DSAMH will collect and monitor all assessments, detentions and non-detentions performed by credentialed mental health screeners, whether a conflict of interest is disclosed or not, for purposes of ensuring that the intent of this law is met and that admissions are appropriate.

Conflict of Interest Disclosure Statement:

☐ No conflicts ☐ Yes, as follows: ______________________________

____

By my signature, I certify that I have duly disclosed any conflicts of interest and I have made careful inquiry into all the facts necessary for me to form my opinion as to the nature and quality of the person's mental disorder. **(psychiatrist must sign and print name).**

______________________________ ______________ ______________
Signature Date and Time

______________________________ ______________
Print Name/Title/Unit Telephone

Certification of Financial Ability to Retain Private Medical, Psychiatric and/or Legal Representation

Based upon financial information obtained from ☐ client ☐ other informant: ______________________________
Name and Relationship

this person can afford to retain legal counsel ☐ **YES** ☐ **NO** can afford to retain a psychiatrist or other qualified medical expert ☐ **YES** ☐ **NO**.

______________________________ ______________
Name of Guarantor (if private legal/psychiatric/medical representation is to be retained) Telephone Number

______________________________ ______________ ________ ________
Street Address City State Zip

The client respectfully prays the court to appoint and assume financial responsibility for the services of ☐ legal counsel ☐ psychiatrist/medical expert.

______________________________ ______________________________
Financial Resource Examiner Name and Date Psychiatric Facility Official Signature and Date

(Fax copy of completed form to DSAMH's Eligibility and Enrollment Unit (302) 255-4416)

DISCHARGE STATEMENT *(to be completed for persons for whom further evaluation can be completed in the community, if necessary, or who have consented to seek treatment voluntarily.)*

I certify that on ________________, __ _________ **a.m. p.m. at** ____
Date (mm/dd/yy) Time (00:00) Location

I have carefully examined ____ ______________________________
Name Date of Birth (mm/dd/yyyy)

and

☐ **I find this person has NOT met the standards of "A person who has a mental illness and is likely to be in danger of hurting him or herself, or others, and to require immediate care, treatment, or detention." (Give a description of the behavior and symptoms)**

AND/OR

☐ **The person is capable of voluntarily consenting to in-patient care or other less-restrictive treatment as required.**

Describe/justify (summarize attached examination findings):

____

____

____

____

____

Describe disposition plans that were provided to this person upon discharge:

____

____

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(Please attach other forms or documents to support your findings)

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Conflict of Interest Disclosure Statement:

☐ No conflicts ☐ Yes, as follows: ____

____

By my signature, I certify that I have duly disclosed any conflicts of interest and I have made careful inquiry into all the facts necessary for me to form my opinion as to the nature and quality of the person's mental disorder. **(psychiatrist must sign and print name).**

____ ________________
Psychiatrist's Signature Date

____ ________________
Print Full Name Email

____ ________________
Practice Address Phone Number