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IN THE CIRCUIT COURT OF _____ COUNTY, WEST VIRGINIA

IN RE: The Involuntary Hospitalization, Treatment Compliance, or Temporary Probable Cause of:

Case No.: _____-MH(TCO/TPC)-_____

Criminal Case No. _____
(if applicable)

_____
RESPONDENT (NAME OF PATIENT)

CERTIFICATE OF LICENSED EXAMINER

West Virginia Code: §§ 27-5-2, 3 & 4, §27-5-11 and §27-6A-1 (et seq.)

Instructions: *All pages of this certificate must be fully completed.*

I, _____ [*Print Name of Licensed Physician, Licensed Psychologist, Court authorized Licensed Independent Clinical Social Worker, or Court authorized Licensed Advanced Nurse Practitioner with Psychiatric Certification or Physician Assistant or Licensed ProfessionalCounselor],* do hereby certify and state as follows:

I have personally observed and examined _____ ***[full name of Respondent]*** whose identifying information is believed to be,

DATE OF BIRTH ____/____/____ ; WEIGHT _____ ; HEIGHT _____

HAIR COLOR _____ ; HAIR LENGTH_____ ;;EYE COLOR _____

SEX ; RACE

RESPONDENT'S LAST KNOWN ADDRESS: _____

_____

PLACE OF BIRTH ***[state or country]*** _____

THE RESPONDENT IS:

A RESIDENT OF _____ COUNTY, _____ STATE

on this date and my findings are as follows:

Date of Examination: ____/____/____ Time: _____

Place of the Examination: _____ ***[Location]***

, _____ *[City]* _____ ***[County]***, West Virginia.

FINDINGS

1. I find there is reason to believe the Respondent ***[initial the appropriate items below]***

_____ **HAS** mental illness _____ **HAS NO** mental illness

_____ **HAS** substance use disorder _____ **HAS NO** substance use disorder

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2. ***If the individual is being certified for substance use disorder, initial the following if it is applicable.***

_____ I recommend that the individual be closely monitored because of the reasonable likelihood that withdrawal or detoxification will cause significant medical complications.

3. I further find that the Respondent *[initial one]* _____ **IS** _____ **IS NOT** likely to cause harm to himself/herself or others DUE TO HIS/HER MENTAL ILLNESS OR SUBSTANCE USE DISORDER.

4. If the selection in question 3 above is "**IS**," it is based on one or more of the following: ***[check all appropriate items from the list of six items below and detail the specific facts under each checked item]***

☐ The individual has inflicted, or attempted to inflict, bodily harm on another: ***[describe]***

☐ ***Criminal Proceedings only*** - The individual is currently committed to a state psychiatric hospital in accordance with W. Va. Code §27-6A-1 *et seq.,* and the individual is a foreseeable danger to self or others outside the hospital setting:***[describe the static and current acute and chronic dynamic risk factors for harm AND how the absence of the individual's personal protective strengths result in the individual being a foreseeable danger]***

☐ The individual by threat or action, has placed others in reasonable fear of physical harm to themselves: ***[describe]***

☐ The individual, by action or inaction, has presented a danger to others in his or her care: *[describe]*

☐ The individual has threatened or attempted suicide or serious bodily harm to himself or herself: ***[describe]***

☐ The individual is behaving in such a manner as to indicate that he or she is unable, without supervision and the assistance of others, to satisfy his or her need for nourishment, medical care, shelter or self-protection and safety so that there is a substantial likelihood that death, serious bodily injury, serious physical debilitation, serious mental debilitation or life-threatening disease will ensue unless adequate treatment is afforded: ***[describe]***

5. ***You must complete this question if you have indicated substance use disorder in question 1.***

The specific manifestations which have occurred WITHIN 30 DAYS prior to the filing of the petition/ application in this action upon which my finding of substance use disorder is based are: ***[Check all that apply; you MUST check at least one.]***

☐ Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home: ***[specify]***

☐ Recurrent substance use in situations in which it is physically hazardous: ***[specify]***

☐ Recurrent substance-related legal problems: ***[specify]***

☐ Continued substance use despite knowledge of having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance: ***[specify]***

6. I received information relevant to this evaluation from the following sources: ***[Consult as many sources as possible; check all that apply]*** ☐ Respondent ☐ Petitioner ☐ Medical Record ☐ Physician ☐ Family Members ☐ Other: ***[list]*** _____

_____

_____

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7. You must complete this question if you have indicated "mental illness" or 'substance use disorder" in question 1.

A. The specific, CURRENT, symptoms and behaviors I HAVE OBSERVED are:

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B. Other current symptoms & behaviors relayed/presented to me by petitioners, witnesses, documents or other sources on which my finding of mental illness and/ or substance use disorder is based on the following

C. Any medical and/or historical symptoms or behaviors prior to the past 72 hours on which my finding of mental illness and/or substance use disorder are based:

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8. Prior history of behavior health services in the following settings:

Type of Treatment	Yes	No	Compliant Yes/No/Unknown	# of Admissions	Most Recent Provider/Hospital	Date
Outpatient	☐	☐				
Voluntary Inpatient or Residential Treatment	☐	☐				
Involuntary Hospitalization	☐	☐				

9. I have identified and considered less restrictive alternative forms of treatment and find that they _____ ARE or _____ ARE NOT appropriate. Please provide detailed explanations as to why or why not each less restrictive alternative forms of treatment are or are not currently appropriate and available.

10. List all medications currently taking, or prescribed and should be taking:

Name of Medication:	Dosage:	Duration:
1.		
2.		
3.		
4.		
5.		

11. Is Medical Clearance Examination NECESSARY? [Check one] ☐ Yes ☐ No ☐ Unknown
If yes, has it been completed or arranged to be completed, prior to involuntary admission to a mental health facility?

Medical Screening was completed at:

Medical Screening arranged to be completed at:

12. Are there any acute medical conditions that require immediate attention? ***[Check one]*** ☐ Yes ☐ No

List the conditions:

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13. The results of my evaluation suggest the following factor(s) are present, or have been present in the past: ***[check all that apply]***

Factors	General Information ***[check if yes, list date(s) when present]***
Thoughts of Suicide	☐ Ideation _____ ☐ Plan _____ ☐ Intent _____ Other Prior History: ***[If yes, explain/give examples]*** ☐ Yes ☐ No
Thoughts of Homicide	☐ Ideation _____ ☐ Plan _____ ☐ Intent _____ Other Prior History: ***[If yes, explain/give examples]*** ☐ Yes ☐ No
Head Injury/ Neurological	☐ Type(s):
Chronic Medical Problems	☐ Type(s):
Limitations to Support System	☐ Type(s):
History of Legal Infractions	☐ Type(s); Explain:
Past History of Harmful Behavior	☐ Type(s):

14. The results of my evaluation suggest the following factors related to substance use disorder are present:

Substance	Amount	Frequency	Route /Method of Use	Date Last Used

Factor(s)	Yes	No	General Information
Public Intoxication Charges	☐	☐	Frequency in Past 90 Days/Dates:
Substance Use to the Point of Incapacitation	☐	☐	Explain:
Employment Instability	☐	☐	Explain:

15. DSM /ICD - Diagnostic Impressions (include all five axes):

16. Clinician Rating of Treatment Needs: ***[check your impression]***

☐ 0: No observable seriously harmful behavior (SHB); No treatment needed.

☐ 1: Slight probability of SHB; Outpatient therapies needed.

☐ 2: Mild probability of SHB; Crisis residential unit (CRU) appropriate. 24-hour supervision needed.

☐ 3: Moderate probability of SHB; Immediate hospitalization in a 24-hour locked facility needed.

☐ 4: High probability of SHB; Should be monitored closely until hospitalized. Immediate hospitalization in a 24-hour locked facility needed.

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17. Based upon such examination and the information contained in this certificate, I therefore certify as follows: *[Initial only ONE of the following recommendations]*

_____ The Respondent should be committed for further evaluation pursuant to § 27-5-3 *[probable cause hearing only]*

_____ If the Respondent is not currently committed in accordance with §27-6A-1 *et seq.*, the Respondent should be fully committed for a period not to exceed 90 days as provided in §27-5-4(1) ***[final commitment hearing only]***

_____ The Respondent should be finally committed for an indeterminate period exceeding 90 days or until this order is modified by this Court pursuant to the provisions of § 27-5-4(l) ***[final commitment hearing only]***

_____ If the Respondent is currently committed in accordance with §27-6A-1 *et seq.,* the Respondent should be finally committed until the court determines that the Respondent's state and current acute and chronic dynamic risk factors for harm can be managed in a less restrictive setting and that the Respondent's personal protective strengths are sufficient to facilitate safety to self and others in such setting as provided in §27-5-4(1)(4) ***[final commitment hearing only]***

_____ The Respondent does not require hospitalization ***[probable cause or final commitment hearing]***

18. ***Initial the following if ALL the matters contained in the statement are applicable.***

_____ Notwithstanding the foregoing, I further believe that the respondent's circumstances make him/her amenable to treatment upon an outpatient basis in a nonhospital or nonresidential setting pursuant to a voluntary treatment agreement and that appropriate outpatient services are available and recommend that the court hear evidence on this issue.

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19. _____ I have explained or attempted to explain the involuntary commitment process to the APPLICANT including the loss of liberty if committed, as well as the likely risks and benefits of commitment.

20. _____ I have explained or attempted to explain the involuntary commitment process to the RESPONDENT including loss of liberty if committed, as well as the likely risks and benefits of commitment.

21. Information regarding examiner completing this certificate: ***[please print or type information]***

Name: _____

Address: ***[city, state, zip]*** _____

Telephone Number: _____ Registration/License Number: _____

License to Practice: ☐ Medicine ☐ Osteopathy ☐ Psychology ☐ Physician Assistant ☐ Social Work
☐ Nursing ☐ Psychiatry ☐ Counselor

Click here to auto-fill date below

_____ _____
Date Examiner's Signature

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22. The person completing this certificate: [check only one]

☐ Is employed by the local Community Mental Health Center: [insert name of Center]

_____

☐ Has contracted to provide examinations for involuntary commitment proceeding with the local Community Mental Health Center: ***[insert name of Center]***

_____

☐ Is neither employed by nor contracts for services with the local Community Mental Health Center.

If this item is checked, you ***MUST*** have the Community Mental Health Center Complete the following:

- The examination reflected by this certificate was as required by law provided or arranged by the Community Mental Health Center or, if the examiner is neither employed or contracted by the Community Mental Health Center, the examination is APPROVED and the Community Behavioral Health Center hereby waives its duty to provide or arrange for this examination.

Click here to auto-fill date below

_____ _____

Date Signature of Center Representative

_____

Title