CAUSE NO. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

THE STATE OF TEXAS § IN THE COUNTY COURT

FOR THE BEST INTEREST §

AND PROTECTION OF § AT LAW NUMBER FOUR OF

§

      (Initials Only), §

THE PROPOSED PATIENT § WILLIAMSON COUNTY, TEXAS

**PHYSICIAN'S CERTIFICATE OF MEDICAL EXAMINATION**

**FOR MENTAL ILLNESS**

I, the undersigned, a person licensed to practice medicine in the State of Texas, or a person employed by an agency of the United States having a license to practice medicine in any state of the United States, do hereby certify, to wit:

1. That my name and address, ***telephone, pager, cell numbers*** are: ***(Physician)***

2. That on the       day of \_\_\_\_\_\_\_\_\_\_\_\_, 2022, at the following location:      , I evaluated and examined      , hereafter called ***"Patient"***.

3 Prior to this examination, the ***Patient***

was

was not

informed that communications with me would not be privileged.

4. The ***Patient***, whose address is      , has been under my care for the following, if any, period of time:     .

5. A brief diagnosis of the physical and mental condition of the Patient on said date is:

6. An accurate description of the mental health treatment, if any, given by me or administered under my direction is as follows:

7. (NOTE: MUST BE COMPLETED IN EVERY CASE TO SHOW PATIENT IS MENTALLY ILL AND MEETS THE CRITERIA FOR COURT-ORDERED MENTAL HEALTH SERVICES)

That I am of the opinion that the Patient is mentally ill, and that as a result of that illness the patient meets at least one of the following additional criteria (check the boxes of the criterion or criteria which apply to the Patient):

is likely to cause serious harm to himself;

is likely to cause serious harm to others;

is suffering severe and abnormal mental, emotional or physical distress; is experiencing substantial mental or physical deterioration of his ability to function independently, which is exhibited by the proposed patient’s inability, except for reasons of indigence, to provide for his basic needs, including food, clothing, health, or safety; and, is unable to make a rational and informed decision as to whether to submit to treatment.

The ***detailed basis*** for this opinion is as follows:

A. On or about       the above-named person ***"stated"*** the following:

(Date)

1."     "

2."     "

3."     "

4."     "

B. On or about       the above-named person ***committed*** the following acts:

(Date)

1.

2.

3.

4.

8. (NOTE: COMPLETE THIS ITEM **ONLY** IF THIS CERTIFICATE IS TO BE OFFERED IN SUPPORT OF A MOTION FOR AN **OPC**. IT IS NOT SUFFICIENT TO RESPOND BY REFERENCE TO ANY OTHER ITEM IN THIS CERTIFICATE.)

That I am further of the opinion that the Patient presents a substantial risk of serious harm to self or others if not immediately restrained, which is demonstrated by (check the box(es) as applicable):

the person's behavior; or

by evidence of severe emotional distress and deterioration in his mental condition to the extent that the person cannot remain at liberty.

The ***detailed basis*** for this opinion is as follows:

1. On or about       the above-named person ***"stated"*** the following:

(Date)

1."     "

2."     "

3."     "

4."     "

1. On or about       the above-named person ***committed*** the following acts:

(Date)

1.

2.

3.

4.

9. (NOTE: COMPLETE THIS ITEM **ONLY** IF THIS CERTIFICATE IS TO BE OFFERED IN SUPPORT OF COURT-ORDERED **EXTENDED** MENTAL HEALTH SERVICES OR A RENEWAL OF SAME.)

That I am additionally of the opinion that the Patient's condition, as set out in item 7 above, is expected to continue for more than 90 days, the detailed basis for this opinion being:

10. (NOTE: COMPLETE THIS STATEMENT **ONLY** IF THIS CERTIFICATE IS TO BE OFFERED IN SUPPORT OF COURT-ORDERED MENTAL HEALTH SERVICES FOR THE PATIENT UNDER A **VOLUNTARY** COMMITMENT WHO REFUSES TO CONSENT TO NECESSARY AND APPROPRIATE TREATMENT.)

The Patient is receiving voluntary inpatient services and has refused necessary and appropriate treatment, and in my opinion:

A. there is no reasonable alternative to the treatment recommended by the physician; and

B. the patient will not benefit from continued inpatient care without the recommended treatment.

YES

NO

Signed and dated this the      day of \_\_\_\_\_\_\_\_\_\_\_\_, 2022.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Examining Physician

Sworn to and subscribed before me this the      day of \_\_\_\_\_\_\_\_\_\_, 2022.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notary Public, State of Texas