DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

Independent Examination, Certification and Recommendations for Placement, Care and Treatment

TDO Facility (if applicable): _____ Case/TDO #: _____

Name: _____ Date of Birth: _____ Gender: _____
(MM/DD/YY)

I conducted an examination of the above named person as follows and made the following findings:

A. Clinical Assessment

Mental Status Exam:

Current use of psychotropic and other medications:

Medical history:

Psychiatric history:

Substance use, abuse or dependency:

Results of substance abuse screening, if applicable:

DIAGNOSIS: DSM IV (P= Provisional, H= Historical)

Axis I : _____ Axis I: _____ Axis I: _____

Axis II: _____ Axis II: _____

Axis III: _____

Axis IV: Psychosocial and Environmental (***Check***): ☐Support Group ☐Social/Environmental ☐Educational ☐ Occupational ☐Housing ☐Economic ☐Health Care ☐ Legal System/Crime ☐Other: _____

Axis V: GAF Current: _____ Highest past year, if known: _____

B. Review of Records and Collateral Information (Check all that apply and summarize)

☐ I have reviewed the temporary detention facility's records for the person, including:

- ☐ The treating physician's evaluation
- ☐ Reports of any laboratory or toxicology tests conducted ☐ Admission forms ☐ Nurses' note, and summarize them as follows:

☐ I have reviewed the following collateral information (specify):

C. Individual's Treatment Preferences (Check all that apply and summarize)
☐ I have discussed or reviewed this individual's treatment preferences with him/her ☐ in person ☐ in a document provided by the person ☐ both in person and in a document provided by the person, and summarize them as follows:

D. Treatment Alternatives:
I assessed the following inpatient and outpatient treatment alternatives (specify):

E. Clinical Evaluation and Risk Assessment Summary (Complete as applicable)**:**

1. Information bearing on likelihood that, as a result of mental illness, the person will, in the near future, cause serious physical harm to himself/herself or others as evidenced by recent behavior causing, attempting, or threatening harm:

(a) If person engaged in recent behavior indicating a risk of serious physical harm toward others, what were the behaviors? (***Check*** all that apply.)
☐ (1) Injured someone ☐ (2) Hit, kicked, pushed someone without injury
☐ (3) Threatened or endangered someone with gun, knife, or other weapon
☐ (4) Verbal threat to seriously physically harm someone ☐ (5) Voiced thoughts of harming someone, without threats
☐ (6) Other type of endangerment: _____

Other information bearing on risk of harm to others:

(b) If person engaged in recent behavior indicating risk of serious physical harm toward self, what were the behaviors? (***Check*** all that apply.)
☐ (1) Ingested pills or poison ☐ (2) Injured self with sharp object ☐ (3) Other injurious behavior: _____
☐ (4) Threatened to commit suicide ☐ (5) Threatened other serious harm ☐ (6)Voiced suicidal thoughts without threats
☐ (7) Other type of self-endangerment:_____

Other information bearing on risk of harm to self:

2. Information bearing on likelihood that, as a result of mental illness, the person will, in the near future, suffer serious harm due to his/her lack capacity to protect himself/herself from harm or to provide for his/her basic human needs:

If person manifested symptoms or engaged in behavior indicating impaired capacity for self-protection or ability to provide for basic needs, what symptoms, deficits or behaviors were noted? (***Check*** all that apply.)
☐ (1) Substantial cognitive impairment (e.g., disorientation, impaired memory) ☐ (2) Hallucination and/or delusions
☐ (3) Neglect of life-sustaining nutrition ☐ (4) Neglect of medical needs ☐ (5) Neglect of financial needs
☐ (6) Neglect of shelter or self-protection ☐ (7) Generalized decline in functioning
☐ (7) Other: _____

Other information bearing on capacity for self-protection or ability to provide for basic needs:

Name of Person: _____ **Case/TDO # _____**

F. Assessment of Individual's Capacity to Accept Treatment (Check all that apply)

- ☐ Able to maintain and communicate choice:
- ☐ Able to understand relevant information;
- ☐ Able to comprehend the situation and its consequences

In my opinion this individual ☐ does or ☐ does not have the capacity to accept treatment for the following reasons:

Certification

I, the undersigned, a qualified examiner pursuant to Virginia Code § 37.2-815, certify that I have this day personally examined

_____
Name of Person

☐ In person or via ☐ two–way electronic video and audio communication system and have probable cause to believe that the person:

- ☐ does not have a mental illness or,
- ☐ has a mental illness and
  - ☐ as a result of mental illness, there is substantial likelihood he or she will, in the near future cause serious physical harm to ☐ himself/herself or ☐ others as evidenced by recent behavior causing, attempting or threatening harm and other relevant information, if any
  - ☐ as a result of mental illness, will suffer serious harm due to his or her lack of capacity to ☐ protect himself/herself from harm or ☐ provide for his/her basic human needs
  - ☐ requires involuntary inpatient treatment or ☐ involuntary outpatient treatment,
  - ☐ none of the above conditions are met and involuntary inpatient or outpatient treatment is not required

Explain the basis for the above certification:

Recommendations for Placement, Care and Treatment

☐ Outpatient Treatment Provider/Services: _____
☐ Inpatient Treatment Provider/Services: _____
☐ Other (Specify):

I am licensed in Virginia as a ☐ psychiatrist by the Board of Medicine ☐ psychologist by the Board of Psychology or ☐ LCSW ☐ LPC ☐ LMFT ☐ psychiatric nurse practitioner ☐ clinical nurse specialist through the Department of Health Professions.

I further certify that I am not related by blood or marriage to the named person, will not be responsible for treating him/her, have no financial interest in the admission or treatment of the person, have no investment interest in the detaining or admitting facility, and unless I am an employee of a state hospital, U.S. Department of Veterans Affairs or a community services board, am not employed by the detaining or admitting facility.

_____ _____
DATE INDEPENDENT EXAMINER

_____
PRINT NAME ADDRESS TELEPHONE NUMBER