DELAWARE HEALTH AND SOCIAL SERVICES
Division of Substance Abuse and Mental Health
1901 N. Dupont Highway, New Castle, DE 19720 Phone: 800-652-2929

24 HOUR EMERGENCY ADMISSION FORM

(Treatment shall not exceed 24 Hours)
(Delaware Code: Title 16, Chapter 51, Section 5122 as Amended 7/92)

STATEMENTS 1, 2, AND 3A MUST BE COMPLETED BEFORE THIS FORM IS PRESENTED TO THE ADMITTING PHYSICIAN:

1. STATEMENT OF COMPLAINT:

I hereby certify that I have knowledge that ____
(Name of person to be admitted)

of____
(Street address, city, state)

appears to have a mental illness and is likely to be in danger of hurting him or herself, or others, and requires immediate care, treatment, or restraint. I certify this because:

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Additional Information:

History of prior psychiatric hospitalizations: Yes_________ No__________ Unknown_______________

If yes, when and where was the most recent admission:____

Prior or current substance abuse or psychiatric treatment: Yes ______ No______ Unknown__________

If yes, where, and therapist's name and phone number:____

Current substance abuse: Yes______ No________ Unknown_________

If yes, what and when last used: ____

Danger to self and others includes, but is not limited to, the following scenarios:

- Expressing suicidal or homicidal thoughts with a plan and means to carry out the threat.
- Inflicting or attempting to inflict serious bodily harm on themselves or others through overdose or physical means, and there is reasonable probability that such conduct will be repeated.
- Experiencing delusions or thought disturbances that place the person in danger, or puts others in danger.

Relationship or other connection with person to be admitted:____

Name and phone number of spouse or closest relative (if known) of person to be admitted: ____________________

____

Signature of person making complaint:______________________________ **Date and Time:**___________________

Print Name: ____ **Phone:**_________________________________

Address:____

2. STATEMENT OF PEACE OFFICER:

I have taken ____, with all reasonable promptness, to a physician licensed in the State of Delaware to practice medicine or surgery. Describe briefly the circumstances, and your observations about this person and their level of danger, to self or others:_______________________________________

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Signature of Officer :___________________________________ Title and Unit:___________________________________

Print Name: ____ Date and Time:________________________________

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3. STATEMENT OF EXAMINING PHYSICIAN:

I certify that I am a physician licensed in the State of Delaware to practice medicine or surgery. I certify that I have

Evaluated_______________________________________ Date: _________________ Time: _________________

Location of Evaluation: ____

(COMPLETE A or B)

A. I have personally examined this person and find that he/she has 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 restraint." And further:

_____ the patient is not willing to accept hospital care and treatment on a voluntary basis.

_____ the patient is incapable of voluntarily consenting to hospital care and treatment.

(Give a description of the behavior and symptoms)

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

Physician Signature:__________________________________ Print Name:______________________________________

(Physician must sign and print name)

Physician's Address and Phone Number: ____

____

I have notified the nearest known relative that the person is being taken to:_______________________________________

Yes_______ No________

(This form is to be forwarded to the receiving hospital with the transporting officer or designee)

B. 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 restraint." ***(Give a description of the behavior and symptoms)***

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What if any disposition plans were provided to this person upon discharge:

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

Physician Signature:_________________________________ Print Name:_____________________________________
(Physician must sign and print name)

Physician's Address and Phone Number:____

____

I have notified the nearest known relative that the person has been released:

Yes_______ No________

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

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4. STATEMENT OF PHYSICIAN ADMITTING TO IN-PATIENT FACILITY:

Nearest known relative notified: Yes_________ No___________

Comments:____

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REQUEST FOR TRANSPORTATION REIMBURSEMENT
FOR PERSONS TREATED UNDER A MENTAL HEALTH COMMITMENT

(Delaware Code: Title 16, Chapter 51, Section 5122 (e) as Amended 6/06)

"(e) The State Treasurer shall pay police officers, constables, sheriffs and deputy sheriffs for service as peace officers under this section at the rate of 31 cents for each mile necessarily traveled and a custody fee of $100 when transporting a mentally ill person from one county to another.

Complaint No:_______________________________ **Date, Time of Complaint:**______________________________

Name of Dept/Troop#____

Address and Phone Number:____

____

Patient Name:____

Date and Time of Transport:____

Name of Transporting Officer: __________________________________ **IBM#**__________________________

Name of Second Officer:____ **IBM#**_________________________

Client Transported: From:_____________________________________

To:____ **# of miles**______________________

Client Transported: From:_____________________________________

To:____ **# of miles**______________________

Total Miles:__________________**@ $0.31 = $**____________

Custody Fee ($100.00) = $____________
***(Custody fee is paid only when a person with a mental illness is transported from one county to another)**

Total Reimbursement Requested: = $____________

I hereby certify that the information on this Reimbursement Form is complete and accurate, and that the above-mentioned patient has been transported to the designated receiving facility in accordance with the Delaware Mental Health Commitment Code.

Name of Officer Completing this Form:____

Signature:____ **Title and Unit:**___________________________________

Print Name:_______________________________________ **Date and Time:**__________________________________

Please mail this form at time of service to:
Division of Substance Abuse and Mental Health
Contracts Unit: Main Administration Building
Herman Holloway Campus
New Castle, Delaware 19720