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

PSYCHIATRISTS' CERTIFICATE FOR PROVISIONAL HOSPITALIZATION*

Fax copy of completed form to DSAMH Eligibility and Enrollment Unit during business hours, Mon.-Fri., 7 a.m.-3 p.m. to 302.622.4162 or outside business hours, to 302.622.4162.

PART I: ASSESSMENT

TO BE COMPLETED BY PSYCHIATRIST

1. Location of Assessment

☐ I am completing this form on behalf of the receiving inpatient hospital;
☐ I am completing this form on behalf of a non-hospital designated psychiatric facility (Part II must be completed by examining psychiatrist at receiving inpatient hospital).

2. Provisional Admission Assessment and Certification

I certify that on _____ at _____
Date (mm/dd/yy) Time (oo:oo) a.m./p.m Location

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

of _____
Street Address City State Zip

and he/she has met the criteria for provisional admission for involuntary inpatient treatment as follows:

☐ He/she is currently held on a 24 hour detention;

☐ He/she appears to be a person with a mental condition (please describe & provide diagnosis if available):

_____
_____
_____
_____

☐ He/she has been offered voluntary inpatient treatment and has declined such care and treatment or lacks the capacity to knowingly and voluntarily consent to such care and treatment (please describe):

_____
_____
_____

☐ He/she poses a threat, based on manifest indications, of being dangerous to self or dangerous to others, as a result of his or her apparent mental condition (please describe):

_____
_____
_____

☐ Less restrictive alternatives have been considered and determined to be clinically inappropriate at this time (please describe):

_____
_____
_____
_____

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

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

3. Assessment of Capacity to Waive Procedural Rights

This person has the capacity to waive procedural rights, including retention of counsel, psychiatrist or other qualified medical expert to testify on his/her behalf at the court hearing ☐ YES ☐ NO

4. Conflict of Interest

I have a conflict of interest created by assessing the above named individual for treatment ☐YES ☐NO

If YES, please describe:

_____
_____
_____

By my signature, I certify that 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 condition.

_____ _____
Psychiatrist's Signature Date

_____ _____
Print Full Name Email

_____ _____
Practice Address Phone Number

PART II: ASSESSMENT UPON TRANFER OF INDIVIDUAL ON PROVISIONAL ADMISSION TO RECEIVING INPATIENT HOSPITAL FROM ANOTHER DESIGNATED PSYCHIATRIC TREATMENT FACILITY

If Part I was completed by psychiatrist at receiving inpatient hospital please skip this Part

TO BE COMPLETED BY PSYCHIATRIST

1. Voluntary Inpatient Treatment

(i) The above named individual was offered voluntary inpatient treatment and accepted such treatment ☐ YES ☐ NO

(ii) ☐ If YES, I certify that this is the least restrictive, most appropriate level of care at this time

(iii) ☐ If YES, I certify that the individual has been provided with the required notifications for voluntary inpatient treatment pursuant to 16 Del. C. § 5003

2. Provisional Admission Assessment and Certification

I certify that on _____ at _____
Date (mm/dd/yy) Time (oo:oo) a.m./p.m. Location

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

of _____
Street Address City State Zip

and he/she meets the criteria for provisional admission for involuntary inpatient treatment ☐ YES ☐ NO.

The reasons for my determination are as follows:

☐ He/she was held on a 24 hour detention prior to being certified for provisional admission;

☐ He/she appears to be a person with a mental condition (please describe & provide diagnosis if available):

_____
_____
_____

☐ He/she has been offered voluntary inpatient treatment and has declined such care and treatment or lacks the capacity to knowingly and voluntarily consent to such care and treatment (please describe):

_____
_____
_____

☐He/she poses a threat, based on manifest indications, of being dangerous to self or dangerous to others, as a result of his or her apparent mental condition (please describe):

_____
_____
_____

☐ Less restrictive alternatives have been considered and determined to be clinically inappropriate at this time (please describe):

_____
_____
_____
_____

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

_____
_____
_____
_____
_____
_____

Conflict of Interest

I have a conflict of interest created by assessing the above named individual for treatment ☐YES ☐NO

If YES, please describe:

_____
_____
_____

3. **Individual MEETS Criteria for Provisional Admission – Assess for Capacity to Waive Procedural Rights** *(if individual does not meet criteria for provisional admission skip to No. 5)*

This person has the capacity to waive procedural rights, including retention of counsel, psychiatrist or other qualified medical expert to testify on his/her behalf at the court hearing ☐ YES ☐ NO

4. **Individual Does NOT MEET Criteria for Provisional Admission - Discharge**

I have completed the provisional admission discharge form and attached it to this packet ☐YES ☐NO

By my signature, I certify that 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 condition.

_____

Psychiatrist's Signature Date

_____

Print Full Name Email

Practice Address Phone Number

PART III: NOTIFICATION OF INDIVIDUAL RIGHTS

TO BE COMPLETED BY PSYCHIATRIST, PSYCHOLOGIST, NURSE, SOCIAL WORKER OR PEER

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.

I acknowledge that I have received this information. _____

Signature of Client Date Time

☐ Individual refused to sign acknowledgment of receipt.

Signature Date

Print Full Name Email

Position Phone Number

PART IV: OTHER INFORMATION

TO BE COMPLETED BY HOSPITAL ADMINISTRATION

1. **Request for Court Hearing**

   (i) The required request for court hearing has been filed as required within 48 hours of provisional admission.

   ☐ YES ☐ NO

   If NO, the reason(s) for the delay is as follows:

_____
_____
_____
_____

2. **Certification of Financial Ability to Retain Attorney and/or Psychiatric/Medical Expert**

   (i) Based upon financial information obtained from

   ☐ Above named individual ☐ Other informant: _____
   Name and Relationship

   (ii) The above named individual can afford to retain an attorney

   ☐ YES ☐ NO

   (iii) The above named individual can afford to retain a psychiatrist or other qualified medical expert

   ☐ YES ☐ NO

3. **Request for Appointment of Attorney and/or Psychiatric/Medical Expert**

The client respectfully prays the court to appoint and assume financial responsibility for the services of

☐ attorney ☐ psychiatrist/medical expert

(continued on next page)

4. Next of Kin

(i) Contact information for the above named individual's next of kin:

Name | Relationship | Phone Number

Address

(ii) The above named individual wishes to notify his/ her next of kin regarding the individual's provisional admission and treatment for apparent mental condition.

☐ YES ☐ NO

(iii) If the above named individual wishes to notify his/her next of kin, is there any information the individual wishes to restrict (ex. location of treatment, details regarding behavior necessitating treatment)?

☐YES ☐NO

If YES, please describe the information to be restricted:

Signature | Date

Print Full Name | Email

Position | Phone Number

Fax copy of completed form to DSAMH's Eligibility and Enrollment Unit (302) 622-4162