FIVE-DAY EMERGENCY COMMITMENT APPLICATION AND PHYSICIAN'S CERTIFICATE ALCOHOL OR DRUG DETOXIFICATION

For a maximum of five (5) days care and treatment in a DMHAS-operated or approved treatment facility; however, if an application for involuntary commitment under section 17a-685 is filed within the five-day period and the treatment facility administrator on the advice of the facility medical officer finds grounds for the commitment, then the person may be detained until the petition has been heard, but no longer than seven days after the filing.
CGS Sec. 17a-684

FAC-14 Rev: 10/00

State of Connecticut
Department of Mental Health and Addiction Services
P.O. Box 341431, 410 Capitol Avenue, 4th Floor
Hartford, CT 06134

Instructions:

1. Both sides of this form **MUST** be completed.
2. The application section must be completed by the person making application for the commitment of another.
3. The physician's certificate must be completed and signed by the examining physician (see reverse).
4. This completed form must be presented to the admitting facility when the patient is received.

To: The Administrator of: _____ (Name of Admitting Facility)			
Name of Patient:	Address:	Telephone No: ( )	Date of Birth: Sex: Male Female

APPLICATION FOR FIVE-DAY EMERGENCY COMMITMENT
(If application is being made by certifying physician, completion of this section is not required – see reverse).

Check box(es) that apply and state facts that support the need for emergency commitment:

A. For commitment of persons intoxicated at the time of application:
I am of the opinion that the above-named person is intoxicated at the time of application for commitment, **and**

(1) is dangerous to him / herself or dangerous to others unless committed,
(2) needs medical treatment for detoxification for potentially life-threatening symptoms of withdrawal from alcohol or drugs,
(3) is incapacitated by alcohol;

or

B. For commitment of persons not intoxicated at the time of application but in immediate need of medical treatment for detoxification:

A licensed physician has determined that the above-named person is in immediate need of medical treatment for detoxification for potentially life-threatening withdrawal symptoms.
Note: A licensed physician must complete the Physician's Certificate on the reverse.

Name of Applicant:	Address:	Telephone No.: ( )
Date:	Signature of Applicant:	Relationship to Patient:

FOR USE BY ADMITTING FACILITY

Accepted: Case Number:	Date of Admission: Time of Admission: _____ am _____ pm	Signature of Examining Physician:
Not Accepted:	Reason Not Accepted:	Referred to: (facility name)

PHYSICIAN'S CERTIFICATE FOR FIVE-DAY EMERGENCY COMMITMENT

This certificate is to be completed and signed by a physician.
The date of examination must be within two days of the date of the certificate.

Name of Patient:	Examined at: (facility name)	Date:	Time: _____ am _____ pm

PART I – EXAMINATION RESULTS

History of Current Episode:

Medication Administered: (dose, date, time)

Physical Findings that Support the Need for Emergency Commitment:

Alcohol or Drug Use:

Urine Drug Screen: _____ Blood Drug Screen: _____ Blood Alcohol Level: _____
Copy of laboratory results must accompany this certificate.

Mental Condition Findings that Support the Need for Commitment:

Previous Hospitalization/Treatment:

PART II – PHYSICIAN CERTIFICATION

M**.D. MUST Check box(es) which apply:**

A. I am of the opinion that the above-named person is intoxicated at the time of this application for commitment **and**

(1) is dangerous to him / herself or dangerous to others unless committed,
(2) needs medical treatment for detoxification for potentially life-threatening symptoms of withdrawal from alcohol or drugs, or
(3) is incapacitated by alcohol:

or

B I am of the opinion that the above-named person is not intoxicated at the time of this application for commitment but is in immediate need of medial treatment for detoxification for detoxification for potentially life-threatening withdrawal symptoms.

Printed Name of Examining Physician:	Signature of Examining Physician:	Conn. Medial License No.
Address:		Telephone Number: ( )

ADDITIONAL COPIES OF THIS FORM ARE AVAILABLE ON THE DMHAS WEBSITE: WWW.DMHAS.STATE.CT.US