NO. _____

THE STATE OF TEXAS
FOR THE BEST INTEREST
AND PROTECTION OF:

IN THE _____ COURT OF

_____ COUNTY, TEXAS

_____
(INITIALS ONLY)

D.O.B.: _____

CERTIFICATE OF MEDICAL EXAMINATION

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

1. My name is _____, M.D./D.O. On the _____ day of _____, 20_____ , at approximately _____ a.m./p.m., at the following location: _____, I evaluated and examined_____ (Name of Proposed Patient), whose address is: _____.

☐ YES ☐ NO - **Prior to the examination, I informed the Proposed Patient that communications with me would not be privileged**.

2. **My diagnosis of the physical and <u>mental condition</u> of the Proposed Patient is:**

_____

_____

3. **The Proposed Patient has been under my care:**
( ) since _____(INDICATE TIME PERIOD). OR
( ) I am performing a consultation evaluation only.

4. **My prior or current treatment, <u>if any</u>, of the Proposed Patient has been as follows:**

_____

_____

5. **In my opinion, the Proposed Patient:** (check all that apply)

( ) is mentally ill; **and**
( ) as a result of that illness is likely to cause serious harm to self; and/or
( ) as a result of that illness is likely to cause serious harm to others; and/or
( ) is suffering severe and abnormal mental, emotional or physical distress; experiencing substantial mental or physical deterioration of the ability to function independently which is exhibited by the inability, except for reasons of indigence, to provide for basic needs, including food, clothing, health or safety; and is not able to make a rational and informed decision as to whether or not to submit to treatment; and/or
( ) is unable to participate in outpatient treatment services effectively and voluntarily and whose mental illness

is severe and persistent, and/or

( ) is chemically dependent and, as a result of that chemical dependence is likely to cause serious harm to self, or is likely to cause serious harm to others, or will, continue to experience deterioration of the ability to function independently and is unable to make a rational and informed decision as to whether or not to submit to treatment.

5. (a) **The factual basis for my opinion is as follows *(Be specific, give all details.)*:**

On or about _____ (***date***), the proposed patient said the following:

_____

_____

_____

_____

_____

5. (b) **On or about _____, the proposed patient committed the following act(s):**

_____

_____

_____

_____

_____

_____

6. ***(Note: Complete this section only if seeking an order of protective custody.)***
I am of the opinion that the Proposed Patient, because of mental illness, presents a substantial risk of serious harm to self or others if not immediately restrained. *(Harm may be demonstrated either by the person's behavior or by evidence of severe emotional distress and deterioration in mental condition to the extent that the person cannot remain at liberty until the time of the hearing).* **The detailed basis for such an opinion is:**

_____

_____

_____

_____

_____

7. ***(Note: Complete this section only if seeking an order for extended mental health services.)***
☐ YES ☐ NO - **I am of the opinion that the Proposed Patient's condition is expected to continue for more than 90 days.**

8. **I recommend that the Proposed Patient receive the following treatment:**

_____

_____

I UNDERSTAND THAT BY SIGNING THIS CERTIFICATE OF MEDICAL EXAMINATION, I MAY BE CALLED/SUBPOENAED TO TESTIFY ABOUT THIS EXAMINATION WITHIN 1 TO 5 DAYS, BEFORE THE PROBATE COURT, HAVING JURISDICTION OVER THIS MATTER. HEARINGS ARE HELD AT _____.

EXECUTED AND SWORN TO UNDER PENALTY OF PERJURY this _____ day of _____, 20____.

_____
(***Physician's Signature)***

SUBSCRIBED AND SWORN TO before me on this _____ day of _____, 20_____.

_____
NOTARY PUBLIC in and for the **STATE OF TEXAS**

My Commission Expires: _____