RESET

Physician's Certificate/
Commitment of Mentally Ill Child
PC-870 REV. 4/19

CONNECTICUT PROBATE COURTS

CONFIDENTIAL

RECEIVED:

Instructions:
1) A physician appointed by the Probate Court must complete this form in connection with a petition for commitment of a mentally ill child. The named physician must be licensed to practice medicine in Connecticut and must have examined the child within 10 days of the hearing.
2) For more information, see C.G.S. section 17a-75 et seq.
3) Type or print the form in ink. Use an additional sheet, or PC-180, if more space is needed.

Probate Court Name | **District Number**

The undersigned, a physician appointed by this court to examine the named child, states that he or she has personally examined the respondent and makes the following report:

Child (Name and present address)

Hereinafter referred to as the child

Date of Examination

Date of Physician's Appointment

Physician (Name, address and telephone number)

Connecticut Medical License No.

Practicing Psychiatrist ☐ Yes ☐ No

Does the child have a mental disorder? ☐ **Yes** ☐ **No**

If yes, you must answer all of the following questions and give reasons for your opinions.

1. What specific type of mental or emotional condition is involved? Give D.S.M. diagnosis.

2. Is the child intellectually disabled? ☐ Yes ☐ No

3. Does the child's mental or emotional condition have substantial adverse effects on his or her ability to function as to jeopardize the child's health, safety or welfare or that of others? ☐ Yes ☐ No

Explain.

CONFIDENTIAL

In the Matter of

4. Is hospitalization for the treatment of mental illness necessary for the child? ☐ Yes ☐ No

Explain.

5. Is a less restrictive placement (other than inpatient hospital placement) recommended for the child? ☐ Yes ☐ No

Pertinent History. (Also indicate who furnished the information and relationship to respondent.)

Physical Condition.

Psychiatric findings and conclusions.

Physician's Certificate/
Commitment of Mentally Ill Child
PC-870 REV. 4/19

CONNECTICUT PROBATE COURTS

CONFIDENTIAL

In the Matter of

I hereby certify that:

I am a physician licensed to practice medicine in the state of Connecticut.

I have practiced medicine for at least one year.

I personally examined the child on the date of examination listed above.

The representations made in this certificate are made under penalty of false statement.

Signature of Examining Physician
Type or Print Name
Date