RESET

Physician's Certificate/Involuntary Commitment/Person with Psychiatric Disabilities/Annual Review
PC-850 REV. 10/19

CONNECTICUT PROBATE COURTS

CONFIDENTIAL

RECEIVED:

Instructions:

1) A Connecticut-licensed physician or psychiatrist appointed by the Probate Court must complete this form in connection with a petition for commitment of an adult with psychiatric disabilities. The named physician or psychiatrist must personally examine the respondent within 10 days of the hearing.
2) The contents of this form will be used by the Probate Court in determining whether the respondent suffers from a psychiatric disability and is in need of treatment.
3) The physician or psychiatrist must respond to each question as fully and completely as reasonably possible.
4) For more information, see C.G.S. section 17a-498 et. seq.
5) Type or print in ink. Use an additional sheet, or PC-180, if more space is needed.

Probate Court Name | **District Number**

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

Respondent (Name and present address)

Hereinafter referred to as the respondent

Date of Examination

Date of Physician's Appointment

Physician (Name, address and telephone number)

Connecticut Medical License No.

Practicing Psychiatrist ☐ Yes ☐ No

Does the respondent have psychiatric disabilities? ☐ **Yes** ☐ **No**

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

1. What specific type of psychiatric disability is involved? Give D.S.M. diagnosis.

2. Is the respondent dangerous to himself or herself? ☐ Yes ☐ No
Explain.

3. Is the respondent dangerous to others? ☐ Yes ☐ No
Explain.

In the Matter of

4. Is the respondent gravely disabled? ☐ Yes ☐ No

Explain.

5. Has the respondent's psychiatric disability resulted in serious disruption of his or her mental and behavioral functioning? ☐ Yes ☐ No

Explain.

6. Will the respondent's psychiatric disability result in serious disruption of his or her mental and behavioral functioning in the future? ☐ Yes ☐ No

Explain.

7. Is inpatient hospital treatment necessary for the respondent? ☐ Yes ☐ No

If yes, is inpatient hospital treatment available and where is it available?

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

If yes, where is a less restrictive placement available?

9. Is the respondent capable of understanding the need to accept treatment on a voluntary basis? ☐ Yes ☐ No

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

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Physical Condition.

Mental Condition.

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 am not connected to the hospital for psychiatric disabilities to which the petition for commitment of the respondent is being made.

I am not related by blood or marriage to either the petitioner or the respondent.

I have notified the patient that all communications, records and information derived from the examination will be disclosed to a third party.

I personally examined the respondent:

☐ within 10 days of the hearing on the petition for commitment or annual review hearing OR

☐ within 15 business days after my appointment to report on the condition of the respondent in connection with an annual review in accordance with C.G.S. section 17a-498(g).

I further certify that the facts stated and information contained in this certificate are true and complete to the best of my knowledge and belief.

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

Signature of Examining Physician

Type or Print Name

Date