

Second Certification by a Psychiatrist

I. IDENTIFYING INFORMATION:

Patient's name: _____

Date of birth: _____

Patient's Current Location:

- Brattleboro Memorial Hospital
- Copley Hospital
- Central Vermont Medical Center
- Center Gifford Medical Center
- Grace Cottage Hospital
- Mt. Ascutney Hospital
- North Country Hospital

- Northeastern Vermont Regional Hospital
- Northwestern Medical Center
- Porter Hospital
- Rutland Regional Medical Center
- Southwestern Vermont Medical Center
- Springfield Hospital
- University of Vermont Medical Center

Other:

- In-person examination
- Telemedicine examination

II. MENTAL STATUS EXAM:

Consciousness Alert Lethargic Somnolent Stuporous Other: _____

Orientation Intact Impaired (describe: _____)

Appearance _____

Attitude Cooperative Uncooperative Guarded Other: _____

Attention/Concentration Good Fair Poor

Psychomotor Normal Slowed Activated Agitated Involuntary Movements

Eye Contact Good Fair Poor

Speech Normal Pressured Rapid Loud Slowed Soft Paucity

Mute Slurred Other: _____

Mood _____

Affect _____ _____

Memory Intact Impaired (describe: _____)

Thought Process/Content: Logical Goal Directed Concrete Circumstantial

Tangential Loose Associations Poverty Blocking Slow

Flight of Ideas Grandiosity Paranoid ideation Delusions

Perception Normal Hallucinations Ideas of Reference:

Insight Good Fair Poor

Judgment Good Fair Poor

Suicidal Ideations No Yes

Describe:

Homicidal Ideations No Yes

Describe:

III. EVIDENCE OF ACUTE OR THREATENING DANGEROUS BEHAVIOR (includes recent events, evidence that the person's behavior poses a danger of imminent harm to self or others):

IV. EVIDENCE OF MENTAL ILLNESS CONNECTED TO BEHAVIOR IN SECTION III:

V. DSM-5 DIAGNOSIS:

I certify that I have today examined this patient _____ and in my opinion, this patient is is not (check one) a person in need of treatment. I base this opinion on my own examination and on review of the assessment and paperwork done by the physician who initiated the EE process and review of the application for the emergency examination. I have made the statements in this certificate under the pains and penalties of perjury.

Certifying Psychiatrist Signature

Date: _____

Time: _____

Certifying Psychiatric Name

Brattleboro Retreat [1 Anna Marsh Lane, Brattleboro, VT 05302]

Central Vermont Medical Center [130 Fisher Road, Berlin, VT 05602]

Rutland Regional Medical Center [160 Allen Street, Rutland, VT 05701]

University of Vermont Medical Center [111 Colchester Avenue, Burlington, VT 05401]

Vermont Psychiatric Care Hospital [350 Fisher Road, Berlin, VT 05663]

Windham Center at Springfield Hospital [1 Hospital Court #12, Bellows Falls, VT 05101]

White River Junction VA Medical Center [215 North Main Street, WRJ, VT 05009]

Other:

I hereby waive any right I have to receive a copy of the notice of hearing from the Court pursuant to 18 V.S.A. § 7613. I understand that despite this waiver I may be called to testify at a hearing involving the above-named proposed patient.

Please fax or securely email a copy of this form to VPCH Admissions Office:

Fax #: 802-828-2749; Phone #: 802-828-2799; Email: AHS.DMHSOC@vermont.gov