PHYSICIAN'S CERTIFICATE/
INVOLUNTARY COMMITMENT/
ANNUAL REVIEW/ PERSON
WITH PSYCHIATRIC DISABILITIES
PC-850 REV. 7/13 Page 1

Replaces Form MHCC-4

STATE OF CONNECTICUT CONFIDENTIAL

COURT OF PROBATE

Instructions: 1. Type or print in ink.
2. Attach additional explanation as needed.
3. The form must be signed under penalty of false statement by a physician licensed to practice medicine in the State of Connecticut.
4. The named physician must personally examine the respondent.

TO: COURT OF PROBATE, **DISTRICT NO.**

The undersigned, a physician 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*]	DATE OF EXAMINATION [*Month, day, year*]
PHYSICIAN [*Name, address and telephone no.*]	DATE OF PHYSICIAN'S APPOINTMENT [*Month, day, year*]
	PRACTICING PSYCHIATRIST ☐ YES ☐ NO
	CONNECTICUT MEDICAL LICENSE NO.

DOES THE RESPONDENT HAVE PSYCHIATRIC DISABILITIES?
☐ **YES** ☐ **NO IF *YES*, ALL OF THE FOLLOWING QUESTIONS MUST BE ANSWERED. YOU *MUST* GIVE REASONS FOR YOUR OPINIONS.**

1. What specific type of psychiatric disability is involved?

2. Is the respondent dangerous to himself or herself ?

3. Is the respondent dangerous to others?

4. Is the respondent gravely disabled?

5. Has the respondent's psychiatric disability resulted in serious disruption of his or her mental and behavioral functioning?

6. Will the respondent's psychiatric disability result in serious disruption of his or her mental and behavioral functioning in the future?

Continued

STATE OF CONNECTICUT CONFIDENTIAL

COURT OF PROBATE

7. Is inpatient hospital treatment necessary for the respondent? Is it available? Where?

8. Is a less restrictive placement (other than inpatient hospital placement) recommended for the respondent? Is it available? Where?

9. Is the respondent capable of understanding the need to accept treatment on a voluntary basis?

PERTINENT HISTORY [*Also indicate who furnished the information and his/her relationship to the respondent.*]

PHYSICAL CONDITION

MENTAL CONDITION

STATE OF CONNECTICUT

COURT OF PROBATE

CONFIDENTIAL

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 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 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 patient in connection with an annual review in accordance with C.G.S. section 17a-498(g).

I further certify, as a result of my examination of the respondent, that, in my opinion, based on the reasons stated above, the respondent has psychiatric disabilities and is:

☐ dangerous to himself or herself.

☐ dangerous to others.

☐ gravely disabled.

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 contained herein are made under the penalties of false statement.

DATE [*Month, Day, Year*]	SIGNED [*Examining Physician*] Print Name:

RESET