| STATE OF SOUTH DAKOTA<br><br>COUNTY OF ______ | )<br>:SS<br>) | THE ______ COUNTY<br>BOARD OF MENTAL ILLNESS |
|---|---|---|

| In the Matter of<br><br>______<br>ALLEGED MENTALLY ILL | CERTIFICATION OF<br>QUALIFIED MENTAL HEALTH<br>PROFESSIONAL OR<br>PHYSICIAN |
|---|---|

I, ______(print name) have seen ______

on the ______ day of ______, 20____, and have made a careful personal examination.

As a result of such examination, I hereby certify that, according to my judgment, said person is mentally ill, and a fit subject for custody and treatment in the hospital for the mentally ill. I also certify that I have stated correctly the answers I have obtained, from the best sources within my knowledge, and from my observation, to the interrogations furnished, which interrogations and answers hereby accompany this certificate, and are given below.

Dated at ______ this ______ day of ______, 20_____.

Signature: ______
Qualified Mental Health Professional

**(1) HISTORY:**

(a) Petitioner/Informant:(1) Name ______
(2) Address ______
(3) Relationship ______

(b) Patient
(1) Full Name ______
(2) Birthplace & Date ______
(3) Sex, Race & Education ______
(4) Occupation ______
(5) Social Security # ______
(6) How long in South Dakota ______ ☐ Homeless
(7) County of Residence & Address ______
______
(8) Marital Status ______

(c) Spouse
(1) Name ______
(2) Address ______

(d) Next of Kin
(1) Full Name ______
(2) Address ______
(3) Relationship ______

(e) Legally responsible (1) Full Name ______
Relative/guardian (2) Address ______
Attorney in Fact (3) Relationship ______

(f) Military Service ______ Yes ______ No

(g) Previous Treatment for Mental Illness – dates, places of treatment, hospitalizations, etc.

☐ Outpatient mental health involvement in past year ______________________________

☐ Hospitalization for mental health in past year ___________________________________

☐ SPMI ☐ No history

Does this patient have a Chronic Disability? ☐ Yes ☐ No. If yes, attach data, Exhibit A.

(h) A review of previous behavior or acts which led to involuntary commitment or treatment which are similar or related to the person's present psychiatric condition or status

☐ Suicidal Ideation ☐Suicidal Gesture ☐ Suicide Threat ☐ Suicide Attempt

☐ Homicidal Threats ☐ Depression ☐ Unable to Care for Self ☐ Dementia ☐ SPMI

☐ Other: ________________________________________________________________

**IF A MINOR:**

(i) Father (1) Full Name ____________________________________________

(2) Address ______________________________________________

(j) Mother (1) Full Name ____________________________________________

(2) Address ______________________________________________

**(2) EXAMINATION FINDINGS**

(a) Physical condition, including any special test results:

________________________________________________________________________

(b) Present Mental Condition:

(c) Is this patient considered to be a danger to self? If so, explain:

(d) Is this patient considered to be a danger to others? If so, explain:

(e) Diagnostic Impression:

(f) Is the person taking any medication or drugs? List them if known. In your opinion, do these have an effect on the person's current behaviors? If so, explain:

(g) In your opinion, could this person benefit from treatment? ☐ Yes ☐ No

If yes, please list the least restrictive alternatives:

(i) Qualified Mental Health Professional: ______________________________________
Signature

(SDCL-27A-10-6)