STATE OF SOUTH DAKOTA)
:SS
COUNTY OF)

THE _____ COUNTY
BOARD OF MENTAL ILLNESS

In the Matter of _____ **ALLEGED MENTALLY ILL**	**CERTIFICATION OF QUALIFIED MENTAL HEALTH PROFESSIONAL OR 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 Relative/guardian Attorney in Fact
(1) Full Name _____
(2) Address _____
(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 _____
☐ SMI ☐ 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 ☐ SMI ☐ Other: _____

IF A MINOR:

(i) Father (1) Full Name _____
(2) Address _____

(j) Mother (1) Full Name _____
(2) Address _____

(1) 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