NO. _____

IN THE MATTER OF **IN THE COUNTY COURT**
TITUS COUNTY,TEXAS

_____

PHYSICIAN'S CERTIFICATE OF MEDICAL EXAMINATION FOR MENTAL ILLNESS

I, the undersigned person, do state under oath that I am a person licensed to practice medicine in the State of Texas, or a person employed by an agency of the United States, and have a license to practice medicine in any State of the United States, and hereby further state under oath, to wit:

1. That my name is: _____

2. That my address is: _____

3. That on the _____ day of _____, 20___, at the following location: _____,

I examined and evaluated _____,

hereinafter called "Patient", whose address is _____

4. The Patient has been under my care for the following period of time, or for examination only:_____

5. A brief diagnosis of the mental and physical condition of the Patient on said date is:

MENTAL: _____

PHYSICAL: _____

6. An accurate description of the mental health treatment, if any, given by me or administered under my direction is as follows: _____

_____

7. That I am of the opinion that the Patient is mentally ill, and as a result of that illness the Patient meets at least one of the following additional criteria for court-ordered mental health services:

☑ is likely to cause serious harm to self; or

☐ is likely to cause serious harm to others; or

☐ is suffering severe and abnormal mental, emotional or physical distress; experiencing substantial mental or physical deterioration of his/her ability to function independently, which is exhibited by the Patient's inability, except for reasons of indigence, to provide for his/her needs, including food, clothing, health, or safety, and is not able to make a rational and informed decision as to whether or not to submit to treatment.

8. The detailed basis of this opinion is as follows: _____

_____

9. *NOTE: COMPLETE THIS SECTION ONLY IF REQUESTING AN O.P.C.*

☐ That I am further of the opinion that the Patient presents a substantial risk of serious harm to self or others if not immediately restrained, which is demonstrated by:

☐ the Patient's behavior; and/or

☐ Evidence of severe emotional distress and deterioration in the Patient's mental condition to the extent that the person cannot remain at liberty.

SIGNED THIS the _____ day of _____, 20____.

_____

Examining Physician

Sworn and subscribed before me on this, the _____ day of _____, 20____.

_____

Notary Public, State of Texas

Printed or typed notary name:_____

My commission expires:_____