

IN THE CIRCUIT COURT OF \_\_\_\_\_ COUNTY, WEST VIRGINIA

*For Clerk's Use Only*

IN RE: INVOLUNTARY HOSPITALIZATION,  
TREATMENT COMPLIANCE, OR TEMPORARY  
PROBABLE CAUSE OF:

CASE NUMBER: \_\_\_\_\_  
(MH, TCO OR TPC #)

\_\_\_\_\_  
RESPONDENT

### CERTIFICATE OF LICENSED EXAMINER

West Virginia Code: §§ 27-5-2, 3 & 4 AND §27-5-11

**Instructions: All pages of this certificate must be fully completed.**

I, \_\_\_\_\_ [*Print Name of Licensed Physician, Licensed Psychologist, Court authorized Licensed Independent Clinical Social Worker, or Court authorized Licensed Advanced Nurse Practitioner with Psychiatric Certification*], do hereby certify and state as follows:

I have personally observed and examined \_\_\_\_\_  
(*Name of Respondent*)

on this date and my findings are as follows:

Date of Examination: \_\_\_\_\_ Time: \_\_\_\_\_

Place of the Examination: \_\_\_\_\_

\_\_\_\_\_, West Virginia.  
(*City*) (County)

### FINDINGS

- I find there is reason to believe the Respondent \_\_\_\_\_ IS \_\_\_\_\_ IS NOT  
[ ] mentally ill [ ] addicted

**[If the individual is being certified for addiction, initial the following if it is applicable]**

\_\_\_\_\_ [*initials*] I recommend that the individual be closely monitored because of the reasonable likelihood that withdrawal or detoxification will cause significant medical complications.

- I further find that the Respondent \_\_\_\_\_ IS \_\_\_\_\_ IS NOT likely to cause harm to him/herself or others DUE TO HIS/HER MENTAL ILLNESS OR ADDICTION.

3. If the selection in question 2 above is "IS," it is based on one or more of the following *[check all appropriate items from the list of five items below and detail the specific facts under each checked item]*:

The individual has inflicted or attempted to inflict bodily harm on another: *[describe]*

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The individual, by threat or action, has placed others in reasonable fear of physical harm to themselves *[describe]*

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The individual, by action or inaction, has presented a danger to others in his or her care: *[describe]*

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The individual has threatened or attempted suicide or serious bodily harm to himself or herself: *[describe]*

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The individual is behaving in such a manner as to indicate that he or she is unable, without supervision and the assistance of others, to satisfy his or her need for nourishment, medical care, shelter or self-protection and safety so that there is a substantial likelihood that death, serious bodily injury, serious physical debilitation, serious mental debilitation or life-threatening disease will ensue unless adequate treatment is afforded: *[describe]*

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4. ***[You must complete this question if you have indicated "mental illness" in question 1.]***

The specific, CURRENT, symptoms and behavior I HAVE OBSERVED on which my finding of mental illness is based are:

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Any other specific symptoms and behavior on which my finding of mental illness is based are:

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5. ***[You must complete this question if you have indicated "addiction" in question 1.]***

The specific manifestations which have occurred WITHIN 30 DAYS prior to the filing of the petition/application in this action upon which my finding of addiction is based are: *[Check all that apply; you MUST check at least one.]*

- Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home

Specify: \_\_\_\_\_

- Recurrent substance use in situations in which it is physically hazardous

Specify: \_\_\_\_\_

- Recurrent substance-related legal problems

Specify: \_\_\_\_\_

- Continued substance use despite knowledge of having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance

Specify: \_\_\_\_\_

Other specific symptoms and behavior on which my finding of "addiction" is based are:

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6. I received information relevant to this evaluation from the following sources [Consult as many sources as possible; check all that apply]:

Respondent     Petitioner     Medical Record     Physician  
 Family Members     Other [list]: \_\_\_\_\_

7. Prior history of behavioral health services in the following settings: (add # for clarity)

Type of Treatment	Yes	No	Unknown	Compliant	Non-Compliant	Date(s)
Outpatient						
Voluntary Inpatient or Residential Treatment						
Previous Commitment(s)						

If "no" marked in outpatient, or voluntary inpatient or residential treatment columns above, why are these less restrictive alternatives *not* being attempted at this time? Explain: \_\_\_\_\_

8. List all medications currently taking, or prescribed and should be taking:

Name of Medication:	Dosage:	Duration:
1.		
2.		
3.		
4.		
5.		

9. Are there any acute medical conditions that require immediate attention? (Circle One) Yes No  
 If "Yes", list the condition(s): \_\_\_\_\_

10. Has a Medical Clearance Exam been completed or arranged to be completed, prior to involuntary admission to a mental health facility. (Circle One) Yes No  
 Medical Screening was completed at: \_\_\_\_\_  
 Medical Screening arranged to be completed at: \_\_\_\_\_

11. The results of my evaluation suggest the following factor(s) are present, or have been present in the past: [check all that apply]

Factors	General Information [check (✓) if yes, list date(s) when present]
Thoughts of Suicide	<input type="checkbox"/> Ideation _____ <input type="checkbox"/> Plan _____ <input type="checkbox"/> Intent _____ Other Prior History <input type="checkbox"/> Yes <input type="checkbox"/> No Explain/give examples: _____ _____
Thoughts of Homicide	<input type="checkbox"/> Ideation _____ <input type="checkbox"/> Plan _____ <input type="checkbox"/> Intent _____ Other Prior History <input type="checkbox"/> Yes <input type="checkbox"/> No Explain/give examples: _____ _____
Head Injury/ Neurological	<input type="checkbox"/> Type(s): _____ _____
Chronic Medical	<input type="checkbox"/> Type(s): _____ _____
Limitations to Support System	<input type="checkbox"/> Explain: _____ _____
History of Legal Infractions	<input type="checkbox"/> Type(s); Explain: _____ _____
Past History of Harmful Behavior	<input type="checkbox"/> Explain: _____ _____

12. The results of my evaluation suggest the following factors related to addiction are present [check all that apply]:

Factor(s)	Yes	No	General Information
Substance Use: Used Periodically?: Used Frequently?: Used Constantly?:	<input type="checkbox"/>	<input type="checkbox"/>	Type(s)/Amount: _____ Type(s)/Amount: _____ Type(s)/Amount: _____
Public Intoxication Charges	<input type="checkbox"/>	<input type="checkbox"/>	Frequency in Past 90 Days / Dates: _____ _____
Substance Abuse to the Point of Incapacitation	<input type="checkbox"/>	<input type="checkbox"/>	Explain: _____ _____
Employment Instability	<input type="checkbox"/>	<input type="checkbox"/>	Explain: _____ _____

13. DSM - Diagnostic Impression (include all five axes): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

14. Clinician Rating of Treatment Needs **[circle your impression]:**

0	1	2	3	4
No observable seriously harmful behavior (SHB). No treatment needed.	Slight probability of SHB. Outpatient therapies needed.	Mild probability of SHB. Crisis residential unit (CRU) appropriate. 24-hour supervision needed.	Moderate probability of SHB. Immediate hospitalization in a 24-hour locked facility needed.	High probability SHB. Should be monitored closely until hospitalized. Immediate hospitalization in a 24-hour locked facility needed.

15. Based upon such examination and the information contained in this certificate, I therefore certify as follows:  
**[Initial only ONE of the following recommendations]:**

- \_\_\_\_\_ The Respondent should be committed for further evaluation pursuant to § 27-5-3 **[probable cause hearing only]**
- \_\_\_\_\_ The Respondent should be finally committed pursuant to § 27-5-4 (k) for a temporary observation period (TOP) not to exceed six (6) months **[final commitment hearing only]**
- \_\_\_\_\_ The Respondent should be finally committed for an indeterminate period pursuant to § 27-5-4 (k) **[final commitment hearing only]**
- \_\_\_\_\_ The Respondent does not require hospitalization **[probable cause or final commitment hearing]**

16. **[Initial the following if ALL the matters contained in the statement are applicable]**

\_\_\_\_\_ Notwithstanding the foregoing, I further believe that the respondent's circumstances make him/her amenable to treatment upon an outpatient basis in a nonhospital or nonresidential setting pursuant to a voluntary treatment agreement and that appropriate outpatient services are available and recommend that the court hear evidence on this issue.

Paragraphs 17 and 18 are to be completed in addition to the forgoing only by examining psychiatrists or licensed psychologists:

17. **[Complete this paragraph only for potential Temporary Probable Cause cases under W. Va. Code § 27-5-11(c): Brooke, Cabell, Hancock, Kanawha, Marion, Ohio, Raleigh, Wirt, & Wood Counties only. Initial if applicable]**

\_\_\_\_\_ Based upon my examination and observation of the Respondent and the information contained in this certificate, I certify that the Respondent is more likely than not to cause serious harm to self or to others as a result of mental illness if not immediately restrained and that the best interests of the Respondent would be served by Respondent's immediate hospitalization.

18. **[Complete this paragraph only for Treatment Compliance cases filed under W. Va. Code § 27-5-11(b): Brooke, Cabell, Hancock, Kanawha, Marion, Ohio, Raleigh, Wirt, & Wood Counties only. Initial all that apply]**

Based upon personal examination of the Respondent and the information contained in this certificate, it is my opinion that:

\_\_\_\_\_ The Respondent, without the aid of medication is likely to cause serious harm to himself or herself or to others.

\_\_\_\_\_ The Respondent, without the aid of prescribed treatment is likely to cause serious harm to himself or herself or to others.

19. Information regarding examiner completing this certificate: **[please print or type information]**

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone Number: ( ) \_\_\_\_\_  
(city) (state) (zip)

License to Practice     Medicine             Social Work            Registration/License Number: \_\_\_\_\_  
                                  Osteopathy             Nursing  
                                  Psychology             Psychiatry

Licensed Independent Social Workers and Advanced Nurse Practitioners with Psychiatric Certification are limited by law to completion of **Probable Cause** examinations, and cannot examine Respondents for Final Commitment proceedings.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

21. The person completing this certificate **[check only one]:**

Is employed by a the local Community Mental Health Center **[insert name of Center]:**

Has contracted to provide examinations for involuntary commitment proceeding with the local Community Mental Health Center **[insert name of Center]:**

- Is neither employed by nor contracts for services with the local Community Mental Health Center.  
If this item is checked, you **MUST** have the Community Mental Health Center complete the following:

The examination reflected by this certificate was as required by law provided or arranged by the Community Mental Health Center or, if the examiner is neither employed or contracted by the Community Mental Health Center, the examination is **APPROVED** and the Community Behavioral Health Center hereby waives its duty to provide or arrange for this examination.

Signature of Center Representative: \_\_\_\_\_

Title: \_\_\_\_\_ Date: \_\_\_\_\_