STATE OF NEW HAMPSHIRE
PETITION AND CERTIFICATE
FOR INVOLUNTARY EMERGENCY ADMISSION (IEA)

_____ Date: ___/___/20___

NAME OF PERSON SOUGHT TO BE ADMITTED

INSTRUCTIONS TO PETITIONER:

1. **Forms:** Complete the enclosed forms to petition for involuntary emergency admission of a person to Cypress Center, Elliot Hospital, or the New Hampshire Hospital. (These are the only **Designated Receiving Facilities** in NH.)

    a. **Petitioner:** Any "reasonable person" may complete an IEA petition and MUST be prepared to testify. The petitioner must include information about the person's behaviors deemed to be **dangerous** as a result of mental illness.

    b. **Physician or APRN: (ONLY)** must complete the Certificate of Examining Physician, as defined in RSA 135-C:2, II-a, and be authorized by a community mental health center or Designated Receiving Facility.

    c. **Witness:** A third person (witness) may include additional information on the petition and should be prepared to testify, but it is **not required.**

2. **Custody:** Following the mental health examination and completion of BOTH forms, a law enforcement officer **shall** take the patient—an ambulance may be used if the patient is a child—(See: RSA 135-C:29(II)) to the facility named in the PHYSICIAN'S CERTIFICATE. If the person refuses an examination by a physician or APRN, the petitioner or law enforcement officer may request a justice of the peace to order the examination by filing a **Complaint and Prayer**.(Check with a hospital social worker.)

3. **Hearing:** The PETITIONER **must** attend an IEA hearing, which will be held by the Circuit Court within **3 days** after admission to Cypress Center, Elliot Hospital, or New Hampshire Hospital (excluding Sundays and Holidays).

4. **Contact:** All petitioners shall contact the **Designated Receiving Facility** (hospital listed below) named on the petition during business hours to find out the date, place, and time of the hearing. If the petitioner does not attend the hearing, in person (or by phone at NHH), the petition may be dismissed and the patient will return to the community.

    - **Cypress Center- (603) 668-4111 ext. 4175** *(**no** phone testimony)*
    - **Elliot Hospital- (603) 663-4400** *(**no** phone testimony)*
    - **NHH Legal Services- (603) 271-5751 or 271-5750** *(phone testimony available)*

Date and Time of Admission to NHH*	Date and Time of IEA Hearing at NHH
Monday 8:00 a.m. – Tuesday 7:59 a.m.	Wednesday @ 1:00 p.m.
Tuesday 8:00 a.m. – Thursday 7:59 a.m.	Friday @ 1:00 p.m.
Thursday 8:00 a.m. – Friday 7:59 a.m.	Monday @ 1:00 p.m.
Friday 8:00 a.m. – Monday 7:59 a.m.	Tuesday @ 1:00 p.m.

***NOTE**: If you wish to testify by telephone at NHH, you must provide NH Hospital with a direct phone number (not a receptionist) and be available when the Court Hearing Officer calls. You may be asked to testify to facts in addition to what you have written on the petition. **You should have a copy of the petition with you, so you can refer to it, during the hearing**.

Form Effective Date: November 1, 2012

STATE OF NEW HAMPSHIRE
PETITION AND CERTIFICATE
FOR INVOLUNTARY EMERGENCY ADMISSION

To the Honorable Judge / Hearing Officer of the ☐ 6th Circuit Court-District Division-Concord:
OR
☐ 9th Circuit Court-District Division-Manchester:

1. I respectfully represent that: Date: _____

_____,
Name of person sought to be admitted *DOB* *Age*

of _____,
 # and Street (Do not list PO Box please) *City* *State* *Zip*

in _____County

needs to be involuntarily admitted, to a Designated Receiving Facility, on an EMERGENCY basis, because s/he is in such a mental condition as a result of mental illness as to pose a likelihood of danger to self or others. I understand that a Designated Receiving Facility is a hospital, in New Hampshire, specifically authorized to treat a person's acute symptoms of mental illness.

2. I believe s/he has engaged in the following dangerous acts: *(check one or more boxes):*

RSA 135-C:27(I) (Danger to self)

☐ (a). Within the past forty (40) days, s/he has inflicted serious bodily injury on him/herself or has attempted suicide or serious self-injury and there is a likelihood the act or attempted act will recur if admission is not ordered. RSA 135 - C:27, 1(a).

☐ (b). Within the past forty (40) days, s/he has threatened to inflict serious bodily injury on him/herself and there is a likelihood that an act or attempt of serious self-injury will occur if admission is not ordered. RSA 135-C:27 1(b).

☐ (c). The person's behavior demonstrates that s/he so lacks the capacity to care for his/her own welfare that there is a likelihood of death, serious bodily injury, or serious debilitation if admission is not ordered. RSA 135-C:27 1(c).

☐ (d). The person meets ***all*** of the following criteria:

(1) The person has been determined to be severely mentally disabled in accordance with rules authorized by RSA 135-C:61 for a period of at least one year;
(2) The person has had at least one probate court involuntary admission, within the last two years, pursuant to RSA 135-C:34-54;
(3) The person has no guardian of the person appointed pursuant to RSA 464-A;
(4) The person is not subject to a conditional discharge granted pursuant to RSA 135-C:49,II;
(5) The person has refused the treatment determined necessary by a mental health program approved by the Department of Health and Human Services; and
(6) A psychiatrist or APRN as defined in RSA 135-C:2, II-a, at a mental health program approved by the Department of Health and Human Services has determined, based upon the person's clinical history, that there is a substantial probability that the person's refusal to accept necessary treatment will lead to death, serious bodily injury, or serious debilitation if Involuntary Emergency Admission is not ordered.

RSA 135-C:27(II) (Danger to others)

☐ Within the past forty (40) days s/he inflicted, attempted to inflict, or threatened to inflict serious bodily harm on another.

1. **Petitioner's name**:_____Relationship:_____

Address: _____
 # and Street (Do not list PO Box please) City State Zip

Telephone No. _____Agency (if any)_____

Describe all specific **DANGEROUS** acts or behaviors that _____
Name of person sought to be admitted.
engaged in. Limit your descriptions to acts or behaviors that happened within the last 40 days:

Dangerous acts or behaviors may include: ***serious bodily injury to self; attempted suicide; threats to harm self or to commit suicide; lack of capacity to provide adequate food, clothing, shelter, and/or maintain a safe personal environment; threats to inflict, or actions that inflicted, or were intended to inflict serious bodily harm on another. Note: Did you personally observe the acts or behaviors? If not, explain how you know about the acts or behaviors.***

Date:_____Time:_____Place_____

Description: _____

Date:_____Time:_____Place_____

Description:_____

REQUIRED SIGNATURE

_____ _____
(Print or type name of petitioner) ***(Signature of petitioner)*** ***(Date)***

Form Effective Date: November 1, 2012

2. **Witness's name**:_____Relationship: _____

Address: _____
 # and Street (Do not list PO Box please) *City* *State* *Zip*

Telephone No. _____Agency (if any)_____

Describe all specific **DANGEROUS** acts or behaviors that _____
Name of person sought to be admitted.
engaged in. Limit your descriptions to acts or behaviors that happened within the last 40 days:

Dangerous acts or behaviors may include: ***serious bodily injury to self; attempted suicide; threats to harm self or to commit suicide; lack of capacity to provide adequate food, clothing, shelter, and/or maintain a safe personal environment; threats to inflict, or actions that inflicted, or were intended to inflict, serious bodily harm on another. Note: Did you personally observe the acts or behaviors? If not, explain, how you know about the acts or behaviors.***

Date:_____Time:_____Place_____

Description: _____

Date:_____Time:_____Place_____

Description:_____

REQUIRED SIGNATURE (Signature needed only if a witness drafts one or more statements above.)

_____ _____
(Print or type name of witness) *(Signature of witness)* *(Date)*

Form Effective Date: November 1, 2012

3. **PHYSICAL EXAMINATION of:** _____

Name of person sought to be admitted

_____

Print Physician's, APRN's, or Designee's name & title. (Sign signature block at the bottom of the page.) Phone Number where reachable.

_____

 # and Street Address (No PO Box please) Town/City State Zip

NOTE: Describe in detail the nature of the physical examination and list any known past or present medical conditions, medications, positive physical findings or other pertinent medical information that the mental health facility may need to know during confinement. If physical examination is not done, state reason.

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(Please make a note above if you are attaching additional pages.)

❑ _____ is medically approved for admission to an inpatient

*(Check box and insert **Patient's Name** on this line, **if** the patient is medically approved for admission.)*

psychiatric **Designated Receiving Facility** (RSA 135-C:2(XIV).

REQUIRED SIGNATURES

_____ *Date:* _____

(Signature of Physician, APRN, or Designee completing page 5.)

_____ *Date:* _____

(Co-Signature of Certifying Physician if Physician Assistant conducts the physical examination.)

Form Effective Date: November 1, 2012

4. **MENTAL EXAMINATION of:** _____

Name of person sought to be admitted

_____

Print Physician's, APRN's, or Designee's name & title. (Sign signature block at bottom of page.) *Phone Number where reachable.*

_____

 # and Street Address (No PO Box please) *Town/City* *State* *Zip*

NOTE: Describe in detail the nature of the examination and list any past or present mental condition, hospitalizations for psychiatric reasons, psychotropic medications, current mental status, orientation, memory, judgment, speech productiveness, coherence, emotional tone, insight, activity level, appearance and any other pertinent information on the person's mental state.

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(Please make a note above if you are attaching <u>additional</u> pages.)

REQUIRED SIGNATURE

_____ *Date:*_____

(Signature of Physician, APRN, or Designee completing page 6.)

_____ *Date:*_____

(Co-Signature of <u>Certifying Physician</u> if Physician Assistant conducts the mental examination.)

Form Effective Date: November 1, 2012

STATE OF NEW HAMPSHIRE
CERTIFICATE OF EXAMINING PHYSICIAN OR APRN
FOR INVOLUNTARY EMERGENCY ADMISSION

I, _____CERTIFY as follows:
PRINT NAME OF CERTIFYING PHYSICIAN or APRN (REQUIRED)

1. I am legally licensed to practice medicine in the State of New Hampshire, or I am licensed by the State of New Hampshire as an APRN, and I am approved to **CERTIFY** involuntary admissions by:

   _____
   (Print name of approved community mental health program or Designated Receiving Facility.)

2. I am not a relative of the person named in this petition who is alleged to be mentally ill.

3. On the _____ day of _____, 20_____, at _____ a.m./p.m., which is within three (3) days of completion of the attached petition, I personally examined:

   _____
   (Name of person sought to be admitted.)

4. I conducted, or designated _____,
   (Print name, degree, & title of designee responsible for conducting the physical examination.)

   to conduct the **PHYSICAL EXAMINATION** of the person, which is completed on page 5.

5. I conducted, or designated _____,
   (Print name, degree, & title of the designee responsible for conducting the mental examination.)

   to conduct the **MENTAL EXAMINATION** of the person, which is completed on page 6.

6. As a result of such examinations which I have completed, and/or reviewed, and the acts or behaviors I observed, or which were reported to me by the petitioner (and witness) listed on the attached petition (pages 2-4), I find and hereby **CERTIFY** that in my opinion, the criteria of RSA 135-C:27 is satisfied, as the person is in such mental condition as a result of mental illness that s/he poses a serious likelihood of danger to self or others.

7. I understand that I may be required to appear in court for a hearing concerning this certificate, especially if my **CERTIFICATE** is illegible.

8. The Designated Receiving Facility which can best provide the degree of security and treatment required by the person sought to be admitted is as follows: ***(check one DRF)***

   Cypress Center _____ *Elliot Hospital* _____ *New Hampshire Hospital* _____

9. I contacted, or designated _____ to
   Printed name of person designated to contact Designated Receiving Facility to approve transport.
   contact the facility named above and conveyed that this Emergency Involuntary Admission is pending.

10. The foregoing statements are true to the best of my knowledge and belief.

    Dated this _____ day of _____, 20____.

REQUIRED SIGNATURE

_____ _____
(Print Name & title of Physician or APRN completing this certificate.) ***(Signature of Physician or APRN completing this certificate.)***

_____
 # and Street Address (No PO Box please) *Town/City* *State* *Zip*

_____
Phone Number where you can be reached.

Form Effective Date: November 1, 2012