COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH
APPLICATION FOR AN AUTHORIZATION OF TEMPORARY INVOLUNTARY HOSPITALIZATION
M.G.L. Chapter 123, Sections 12 (a) and 12 (b)

Application Pursuant to Section 12 (a)

1) Application to (Facility Name): _____

2) I hereby apply for admission of (Name of Individual): _____

Address: _____ City/Town: _____ State: _____

Social Security Number: _____ Date of Birth: _____ Sex: M ☐ F ☐

to the facility named above pursuant to M.G.L. c. 123, s. 12 (a). I hereby authorize transport and the use of restraint of the person named above but only if necessary for the safety of the person being transported or of others who are likely to come into contact with him or her. M.G.L. Chapter 123, s. 21.

Based on my examination[1], it is my opinion that the person requires hospitalization at the above named facility so as to avoid the likelihood of serious harm by reason of mental illness. Evidence supporting my opinion includes:

A). Mental Illness: For purposes of admission to an inpatient facility under Section 12, "Mental Illness" means a substantial disorder of thought, mood, perception, orientation, or memory which grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life. Symptoms caused solely by intellectual or developmental disabilities, autism spectrum disorder, traumatic brain injury or psychiatric or behavioral disorders or symptoms due to another medical condition as provided in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by the American Psychiatric Association, or except as provided in 104 CMR 27.18, alcohol and substance use disorders do not constitute a serious mental illness; provided, however, that the presence of such conditions co-occurring with a mental illness shall not disqualify a person who otherwise meets the criteria for admission to a mental health facility. Specify evidence including behavior and symptoms: _____

_____

_____

B). Likelihood of Serious Harm (check all categories that apply):

☐ (1) Substantial risk of physical harm to the person himself/herself as manifested by evidence of threats of, or attempts at suicide or serious bodily harm and/or

☐ (2) Substantial risk of physical harm to other persons as manifested by evidence of homicidal or other violent behavior or evidence that others are placed in reasonable fear of violent behavior and serious physical harm to them; and/or

☐ (3) Very substantial risk of physical impairment or injury to the person himself/herself as manifested by evidence that such person's judgment is so affected that he/she is unable to protect himself/herself in the community and the reasonable provision of his/her protection is not available in the community.

Specify evidence including behavior and symptoms: _____

_____

_____

3) Applicant Certification (check all applicable boxes)

a) I am a: ☐ Licensed Physician ☐ Qualified (i.e. Licensed) Psychologist ☐ Advanced Practice Registered Nurse ☐ Licensed independent Clinical Social Worker (LICSW) ☐ Police Officer

b) ☐ I have; I have not ☐ personally examined this person. If not, why? _____

_____

c) ☐ I have consulted with either the receiving facility or emergency screening program.

d) ☐ I have not so consulted because: _____

_____

Print Applicant's Name (Not Patient): _____ Phone: _____

Address: _____ City/Town: _____ State: _____

Applicant's Signature: _____ Date: _____ Time: _____

NOTE: Parts 1) through 3), above, must be completed to apply for involuntary hospitalization.

[1] If an examination is not possible because of the emergency nature of the case and because of the refusal of the person to consent to such examination, the physician, qualified psychologist, advanced practice registered nurse or licensed independent clinical social worker on the basis of the facts and circumstances may determine that hospitalization is necessary and may apply therefore. G.L. c.123 s.12(a)

COMMONWEALTH OF MASSACHUSETTS **DEPARTMENT OF MENTAL HEALTH**

Authorization Pursuant to Section 12 (b)

Designated Clinician* Authorization:

(Note: Boxes A. through G., below, must be checked to authorize a Section 12(b) involuntary admission to a facility.)

☐ A. I am a designated clinician* of the aforementioned facility with authority to authorize admissions under Section 12 (b).

☐ B. I have personally examined this person:

☐ within 2 hours of his/her arrival at the facility

☐ more than 2 hours after his/her arrival at the facility due to the fact that I was engaged in an emergency situation.** The emergency situation was: _____

_____

_____and I examined the patient at:_____am/pm.

☐ C. This person does not require emergency or inpatient medical or surgical care.

☐ D. I have offered this person an application for Care and Treatment on a Conditional Voluntary Basis and the person: *(one of the two boxes below must be checked to proceed with a Section 12(b) authorization)*

☐ refused to sign, or

☐ the application was rejected (the reasons why the application was rejected must be stated on the application and the rejected application shall become part of this person's medical record at the facility).

***Note**: 104 CMR 27.07 (1) requires that the patient be offered an opportunity to change to conditional voluntary status again within three days of admission.*

☐ E. I concur with the applicant's recommendation and have completed a psychiatric examination to support this conclusion. Alternatively, I am the applicant, I have personally examined this person, and have completed sections **1)**, **2), 2A)** and **2B)** on the opposite side of this form.

☐ F. In my opinion, at the present time there is no less restrictive placement that is appropriate for this person to which he or she is willing to go.

☐ G. I authorize this person's admission.

☐ H. I reject this application for admission for the following reasons: _____

_____

_____

_____

Designated Clinician's Name (print):_____Phone:_____

Address:_____

Address:_____

City:_____State:_____

Designated Clinician's Signature:_____

Date:_____ Time:_____

***** A physician or qualified advanced practice registered nurse, authorized, as applicable, by the Department pursuant to 104 CMR 33.00

****** See 104 CMR 27.07 (2)