

**CORRECTIONAL MANAGED HEALTH CARE - MENTAL HEALTH SERVICES  
CERTIFICATE OF EMERGENCY COMPELLED PSYCHOACTIVE MEDICATION  
IN A MENTALLY ILL PERSON**

Name:

TDCJ #:

Facility:

Patient appears to be an imminent danger to himself and/or others.

Specify exact signs, symptoms and behaviors of dangerousness: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**REQUIRED DOCUMENTATION**

- Clinical progress notes of patient's dangerousness to self and/or others.
- Clinical progress notes of patient's refusal to voluntarily accept prescribed medication.
- Physicians order for enforcement of medication, duration not to exceed a single dose.

On the basis of professional evaluation, the patient's condition requires enforcement of psychotropic medication.

\_\_\_\_\_  
Physician/MLP Signature

\_\_\_\_\_  
Date/Time

- Patient voluntarily accepted medication; no enforcement occurred
- Enforcement of medications occurred

By my signature below, I attest that the requirements governing compelled psychoactive medication have been met.

\_\_\_\_\_  
Clinical Director Signature

\_\_\_\_\_  
Date/Time

Copies: Facility QI/QM Committee  
Director of Mental Health Services (Include copies of corresponding documentation)