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)