

**TEXAS DEPARTMENT OF CRIMINAL JUSTICE
MENTAL HEALTH SERVICES**

**CERTIFICATE OF NON-EMERGENCY COMPELLED PSYCHOACTIVE MEDICATION
IN A MENTALLY ILL PERSON**

Name: _____ DOB: _____ TDCJ #: _____ Facility: _____

Patient appears to be an imminent danger to self or others: () Yes () No

If yes, specify exact signs, symptoms and behaviors of dangerousness:

Patient appears to be at risk for mental and/or physical deterioration that will cause undue suffering: () Yes () No

If yes, specify exact signs, symptoms and behaviors of deterioration:

Required documentation has been made:

_____ Clinical progress notes of patient's deterioration and/or dangerousness to self and/or others

_____ Clinical progress notes of patient's refusal to voluntarily accept prescribed medication

_____ Documentation of Administrative Due Process Hearing

_____ Documentation of attempts to persuade patient to comply with prescribed medication subsequent to Due Process Hearing

Physician's order for enforcement of medication, valid for no longer than 30 days.

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

Treating Psychiatrist/MLP

Date/Time

Non-Treating Psychiatrist/MLP

Date/Time

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

Clinical Director

Date/Time

Copies: Facility QI/QM Committee
Director of Mental Health Services

HSP-1 (Rev. 9/99)