APPLICATION FOR INVOLUNTARY EMERGENCY HOSPITALIZATION FOR MENTAL ILLNESS

FOR HOSPITAL USE ONLY
Date Admitted
Hospital Register No.
Approval of Hospital Official
Signature Date

(Complete in Triplicate)
STATE OF SOUTH CAROLINA)
COUNTY OF _____)

IN THE MATTER OF:

Person alleged to be mentally ill | Sex | Birthdate | Age | Race | Marital Status

Street Address | City | State | Zip | Phone # | Length of Time Residing There

TO THE HOSPITAL DIRECTOR:

Application is hereby made for the INVOLUNTARY EMERGENCY ADMISSION of the aboved-named person to a SCDMH Psychiatric Hospital

or to _____
NAME OF NON-SCDMH HOSPITAL

for the following reasons:
That the undersigned believes that the aboved-named person is mentally ill, and because of this mental condition is likely to cause serious harm to self or others if not immediately hospitalized.

1. The specific type of serious harm thought probable is:

2. That the applicant bases his/her belief on the following grounds:

3. That the applicant understands that for Involuntary Emergency Admission to occur that the said person must be examined and certified by at least one licensed physician (Part II, Certificate of Licensed Physician for Mental Illness) as required by Section 44-17-410, S.C. Code, 1976, as amended. If the said person has not been examined, listed below are the reasons:

4. That next-of-kin of allegedly mental ill person is _____
Name

Relation _____ Whose address is _____
RFD or Street | City and State | Zip | Phone Number

In case of next-of-kin cannot be contacted, notify _____

Relation | Address | City and State | Zip | Phone Number

SWORN to before me this

_____ day of _____.

_____
Notary Public for South Carolina or Probate Judge

My Commission Expires: _____

WHEREFORE, the undersigned requests that the person named above be admitted to a psychiatric hospital for treatment as authorized by law.

X _____
Applicant's Signature

_____
Name of Applicant (typed or printed)

_____
Address of Applicant

_____
Telephone Number of Applicant

_____
Relation to Patient or Title, if any

(See reverse side which must be completed)

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IMPORTANT NOTICE: All patients receiving treatment in a State Department of Mental Health facility will be charged the established fee as approved by the South Carolina Mental Health Commission.

PERTINENT FINANCIAL RESPONSIBILITY INFORMATION

Present Name		Full Name at Birth if Different From Present	
Education Level	**Social Security Number**	**Occupation**	**Monthly Income**
Employer's Name	**Address**	**If not employed, source of income:**	
		Retirement	**Public Assistance** / **Other**
		$	$ / $

HOSPITALIZATION INSURANCE Coverage including group insurance, Medicare, Medicaid, Military medical care, etc.

Policy No. or HIB	Name of Insurance Co.	Address	If group insurance, name & address of firm

MILITARY SERVICE

Branch	Service Number	Dates of Service	Type Discharge	Monthly Pension	VA Claim No.
				$	

FINANCIAL REPRESENTATIVE Please list the name, address and telephone numbers of the person to receive financial statements and other media related to the personal financial affairs on behalf of the patient

Last Name	First Name	Middle Initial	Relation to Patient	Street Address or Rural Route & Box	Telephone
				City, State, Zip	Telephone

LIST OF SCDMH PSYCHIATRIC HOSPITAL

Division of Inpatient Services G. Werber Bryan Psychiatric Hospital 220 Falson Drive, Columbia, S.C. 29203 For information and prior to all admissions call: (803) 935-7143 – All Hours	Division of Inpatient Services Bryan Psychiatric Hospital Wellspring 2100 Bull Street, Columbia, S.C. 29202 For information and prior to all admissions call: (803) 898-2038 – All Hours	Division of Inpatient Services William S. Hall Psychiatric Institute 1800 Colonial Dr., P.O. Box 202 Columbia, S.C. 29202
Patrick B. Harris Psychiatric Hospital P.O. Box 2907, Anderson, S.C. 29622 For information and prior to all admissions call: (864) 231-2600 – All Hours	Division of Inpatient Services Forensics Evaluation and Treatment Services 7901 Farrow Road, Columbia, S.C. 29203 For information and prior to all admissions call: (803) 935-6334 or (803) 898-2038 – All Hours	Psychiatry Unit Forensic Unit Children's Unit For information and prior to all admissions call: (803) 898-1662 – All Hours

NOTE: ADMINISTRATIVE PROCEDURE – FORMS:

"Application for Emergency Admission, Part I", and "Certificate of Licensed Physician, Part II", must be completed in triplicate and accompany the patient to the receiving hospital. The hospital must forward one copy to Judge of Probate of the county in accordance with 44-17-410(3) and retain one copy in the person's hospital record. ADMISSION MUST BE WITHIN SEVENTY-TWO HOURS OF THE DATE OF THE CERTIFICATION OF THE LICENSED PHYSICIAN, (PART II).

NOTE: TO LICENSED PHYSICIAN:

1. The licensed physician must consult with the local State Community Mental Health Center regarding the commitment/admission process and the available treatment options and alternatives in lieu of hospitalization at a state psychiatric facility. (Section 44-17-460, S.C. Code, 1976, as amended).
2. The licensed physician must also consult via telephone with the admitting physician of the receiving hospital regarding the appropriateness of admission and the persons mental and physical treatment needs.

NOTE: TO POLICE AND OTHER OFFICERS OF THE PEACE:

The certificate of a licensed physician authorizes and requires taking the proposed patient into custody. Section 44-17-440, South Carolina Code of Laws, 1976, as amended: "The certificate required by item 2 of Section 44-17-410 shall authorize and require any officer of the peace, preferably in civilian clothes, to take the individual into custody and transport him to the hospital designated by the certification. No person shall be taken into custody after the expiration of three days from the date of the certification. Any friend or relative may transport the individual to the mental health facility designated in the application, provided such friend or relative has read and signed a statement on the certificate which clearly states that it is the responsibility as an officer of the peace to transport the patient shall not be entitled to reimbursement from the State for the cost of such transportation. Any officer acting in accordance with the provisions of this article shall be immune from civil liability."

NOTE: TO FRIENDS AND RELATIVES:

It is the responsibility of an officer of the peace to provide timely transportation of the person alleged to be mentally ill to the designated mental health facility. However, by freely signing this statement, you can choose to assume that responsibility. Transportation must begin immediately. This form must be hand delivered by you to the admissions office of the designated mental health facility at the time of admission.

Date Signature of Friend or Relative/Relationship

PART II
CERTIFICATE OF LICENSED PHYSICIAN
EXAMINATION FOR EMERGENCY ADMISSION

NAME OF PERSON EXAMINED _____ AGE _____ COUNTY OF RESIDENCE _____

PLACE OF EXAMINATION _____ HOUR AND DATE OF EXAMINATION _____

I, THE UNDERSIGNED LICENSED PHYSICIAN, have examined the above-named person and am of the opinion that the said individual:

☐ IS MENTALLY ILL AND because of this mental condition CURRENTLY POSES A SUBSTANTIAL RISK of physical harm to self and/or others to the extent that INVOLUNTARY EMERGENCY HOSPITALIZATION is recommended.

My recommendation for INVOLUNTARY EMERGENCY HOSPITALIZATION is based on the following symptoms and specific examples of behavior which indicate mental illness and probable risk of harm:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

The person is therefore to be transported to _____
NAME OF SCDMH PSYCHIATRIC HOSPITAL

or to _____ for involuntary emergency admission.
NAME OF NON-SCDMH HOSPITAL

For admission to SCDMH hospital, Physician must complete Part II, Page 2, over.

_____, M.D. _____
SIGNATURE OF LICENSED PHYSICIAN S.C. LICENSE NUMBER

_____, M.D. _____
TYPED OR PRINTED NAME PHONE NUMBER

_____
ADDRESS

_____

All information MUST be typed or clearly printed