STATE OF HAWAII DEPARTMENT OF HEALTH BEHAVIORAL HEALTH ADMINISTRATION	**STATEMENT BY A HEALTH CARE PROVIDER FOR EMERGENCY EXAMINATION**	JOSH GREEN, M.D. GOVERNOR KE KIA-AINA

Date: _____

To: _____
(Designated Receiving Facility Administrator)

Facility: _____

THIS FORM MUST ACCOMPANY THE INDIVIDUAL. PURSUANT TO HRS **§ 334-E** THE UNDERSIGNED LAW ENFORCEMENT OFFICER HEREBY APPLIES FOR THE EMERGENCY EXAMINATION OF:

INDIVIDUAL'S NAME: _____

MODE OF TRANSPORTATION

☐ LAW ENFORCEMENT Only

☐ LAW ENFORCEMENT + EMS

☐ LAW ENFORCEMENT + AMR

☐ LAW ENFORCEMENT + CORE

SUBJECT INFORMATION

☐ HOMELESS

HOUSED: ☐ TEMPORARY ☐ PERMANENT

ADDRESS OR LOCATION OF INDIVIDUAL:

_____

_____

PHONE NUMBER: (_____)_____

DATE OF BIRTH: _____

MILITARY AFFILIATION: YES ☐ NO ☐

GENDER: ☐ CIS MALE ☐ CIS FEMALE ☐ OTHER

☐ TRANGENDER – MTF☐ TRANSGENDER – FTM

IF INDIVIDUAL IS A MINOR

Parent/Guardian Name: _____ Phone: _____

Address: _____

INDIVIDUAL'S EMERGENCY CONTACT INFORMATION

Name: _____ Phone: _____

Relation to Subject: _____

By signing below, I attest that this form is true and complete. I acknowledge that I am required to submit a copy of this form to the Department of Health within five (5) business days to:

Mailing address: P. O. Box 3378, Honolulu, HI. 96801; or Email Address: DOH.MH3@doh.hawaii.gov

Health Care Provider Signature: _____

Health Care Provider Name: _____

Professional Credentials: ☐ Licensed physician ☐ Advanced practice registered nurse ☐ Physician assistant

☐ Licensed clinical social worker ☐ Psychologist

Specialty: _____

Hawaii Healthcare License Number: _____

Organization Affiliated with: _____

Phone: _____

Business Address: _____

Determination of the Health Care Provider (check all that applies):

1. The person is ☐ Mentally ill and/or ☐ Suffering from substance use

As evidenced by _____

2. The person is imminently dangerous to ☐ Self and/or ☐ Others.

As evidenced by _____

The above-named individual was detained and transported to a facility for an emergency examination due to the following (Describe the circumstances, including the date, time, place of interaction, nature of the provider and the individual's relationship, and the behaviors, statements of threats/attempts as **directly observed** by the health care provider).

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Please list any known medical concerns. This will assist in most appropriately triaging the individual.

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Please list any treatment provided to the INDIVIDUAL, within the examining health care provider's scope of practice, which was deemed to be medically necessary for the INDIVIDUAL's safe transportation. If medication was given, please document dose, mode of administration, date/time, lot number of product (if applicable), and prescribing clinician:

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_____

_____

_____

Officer Name: _____ Badge Number: _____

CIT-trained: ____ YES _____ NO

Law Enforcement Report No.: _____

Law Enforcement Agency: _____

County: _____ District: _____

Coordination with Mental Health Emergency Worker (Name): _____