

STATE OF LOUISIANA
LOUISIANA DEPARTMENT OF HEALTH – OFFICE OF BEHAVIORAL HEALTH
PHYSICIAN’S EMERGENCY CERTIFICATE

For observation, diagnosis, and treatment at a treatment facility for a period not to exceed 15 days, or 28 days, for substance abuse (Title 28:52.4). See Louisiana Revised Statutes, Title 28, Sections 53 and 63. These directives must be fulfilled in order for this certificate to be valid.

NAME OF EXAMINING PHYSICIAN:	EXAMINATION DATE:	EXAMINATION TIME:		
ADDRESS OF EXAMINING PHYSICIAN:				
PATIENT DATA	NAME OF PATIENT			
	ADDRESS OF PATIENT			
	RACE	SEX <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH	BIRTHPLACE
	MARRITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> SEP		MILITARY STATUS <input type="checkbox"/> VETERAN <input type="checkbox"/> NON-VETERAN	RELIGION
	NAME OF NEAREST RELATIVE, FRIEND, OR GUARDIAN			RELATIONSHIP
	ADDRESS			PHONE NUMBER
CHECK: <input type="checkbox"/> Mental Illness or Substance Abuse (15 Day) <input type="checkbox"/> Substance Abuse (28 Day) <input type="checkbox"/> 1 st <input type="checkbox"/> 2 nd Order For Protective Custody Date: _____				
FINDINGS OF EXAMINATION				
HISTORY OF PRESENT ILLNESS (REASONS FOR ADMISSION, INCLUDING BEHAVIOR, ACTS, THREATS, ETC.)				
PHYSICAL FINDINGS (MEDICAL HISTORY, CURRENT MEDICATIONS, ETC.)				
MENTAL CONDITION (ORIENTATION, MOOD, THOUGHT CONTENT, AFFECT, ANY HALLUCINATIONS OR DELUSIONS)				
PREVIOUS PSYCHIATRIC TREATMENT <input type="checkbox"/> INPATIENT <input type="checkbox"/> OUTPATIENT	DATE OF TREATMENT	PLACE, IF KNOWN		
IS PATIENT CURRENTLY: <input type="checkbox"/> SUICIDAL <input type="checkbox"/> HOMICIDAL <input type="checkbox"/> VIOLENT				
I am of the opinion that the above person named is in need of immediate psychiatric treatment in a treatment facility because he/she is seriously mentally ill or suffering from substance abuse so that he/she is (check where appropriate in both 1 & 2): 1. <input type="checkbox"/> Dangerous to self <input type="checkbox"/> Dangerous to others <input type="checkbox"/> Gravely disabled 2. <input type="checkbox"/> Unwilling <input type="checkbox"/> Unable to seek voluntary admission				
SIGNATURE OF EXAMINING PHYSICIAN	LA MEDICAL LICENSE NUMBER	DATE SIGNED	TIME SIGNED	
Completion of above certificate shall constitute legal authority to transport patient to the following facility: 1. _____ 2. _____ To be transported by: _____ Relationship to patient: _____				