Request for Involuntary Examination after Stabilization of Emergency Medical Condition _____, for whom an involuntary examination has been The following individual initiated has been evaluated or treated at Hospital located at for an emergency medical condition. (a) The individual arrived at this hospital at: am pm on , 20 . (b) The attending physician documented that the individual had an emergency medical condition at: (c) The attending physician documented at _____ am pm on _____, 20___. That the individual's medical condition had stabilized, or That an emergency medical condition did not exist This hospital is notifying designated receiving facility or the psychiatric unit within this hospital, within two (2) hours of the time noted in (c) above that the individual must be examined by a designated receiving facility and released; or the individual must be transferred to a designated receiving facility in which appropriate medical treatment is available. Within 12 hours of the time noted in (c) above, the designated receiving facility: (check one or both boxes) Shall perform the involuntary examination at this hospital, or Shall, if it has available the appropriate medical treatment, accept transfer of the individual. The nature and extent of this individual's current medical problems: This hospital, pursuant to ss. 394.462 and 394.4685, F.S., will provide or secure transport of this individual via: with expected time of arrival of: _____ am pm on _____, 20____ unless other methods of transportation have been arranged as specified:

* Transfers of individuals in a psychiatric emergency must be performed in compliance with the federal EMTALA law. This completed form must be given to the receiving facility with the form initiating the involuntary examination prior to or at the time of the transfer of the individual with a copy retained in the clinical record. The individual shall not be held for involuntary examination longer than a total of 72 hours plus the period during which an emergency medical condition was declared by the attending physician.

Date

Name of Hospital

Time

Credentials

Signature of Administrator or Designee

Typed or Printed Name