

STATE OF SOUTH DAKOTA )  
 : SS  
County of \_\_\_\_\_ )

The \_\_\_\_\_ County Board

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In the Matter of

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CERTIFICATION OF  
QUALIFIED MENTAL HEALTH PROFESSIONAL  
OR PHYSICIAN

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I have seen \_\_\_\_\_ on the \_\_\_\_\_ day of \_\_\_\_\_,  
2013 and have made a careful personal examination.

As a result of such examination, I hereby certify that, according to my judgment, said person is mentally ill and a fit subject for custody and treatment in the hospital for the mentally ill. I also certify that I have stated correctly the answers I have obtained, from the best sources within my knowledge, and from my observation, to the interrogations furnished, which interrogations and answers hereby accompany this certificate and are given below.

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

Signature: \_\_\_\_\_  
Qualified Mental Health Professional

(1) HISTORY  
(a) Informant:

(1) Name \_\_\_\_\_

(2) Address \_\_\_\_\_

(3) Relationship \_\_\_\_\_

(b) Patient

(1) Full Name \_\_\_\_\_

(2) Born-Place, Date \_\_\_\_\_

(3) Sex, Race, Education \_\_\_\_\_

(4) Occupation \_\_\_\_\_

(5) Social Security No. \_\_\_\_\_

(6) How Long in South Dakota \_\_\_\_\_

(7) Marital Status \_\_\_\_\_

(c) Wife/Husband

(1) Name \_\_\_\_\_

(2) Address \_\_\_\_\_

(d) Father:  
(If a minor)

(1) Full Name \_\_\_\_\_

(2) Address \_\_\_\_\_

(e) Mother:  
(If a minor)

(1) Full Name \_\_\_\_\_

(2) Address \_\_\_\_\_

(f) Next of Kin

(1) Full Name \_\_\_\_\_

(2) Address \_\_\_\_\_

(3) Relationship \_\_\_\_\_

(g) Legally responsible relative/guardian (1) Full name \_\_\_\_\_  
(2) Address \_\_\_\_\_  
(3) Relationship \_\_\_\_\_

(h) Military Service: \_\_\_\_\_ Yes \_\_\_\_\_ No

(i) Previous Treatment for Mental Illness: Give dates, places of treatment, dates of previous Hospitalizations, etc. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(j) A review of previous behavior or acts which led to involuntary commitment or treatment which are similar or related to the person's present psychiatric condition or status: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(2) EXAMINATION FINDINGS

(a) Physical condition, including any special test results: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(b) Present Mental Condition: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(c) Is this patient considered to be a danger to himself? If so, explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(d) Is this patient considered to be a danger to others? If so, explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(e) Diagnostic Impression: \_\_\_\_\_  
\_\_\_\_\_

(f) Is this person taking any medication or drugs? List them if known. In your opinion, do these have an effect on the person's current behaviors? If so, explain: \_\_\_\_\_  
\_\_\_\_\_

(g) In your opinion, could this person benefit from treatment? If so, please list the least restrictive alternatives: \_\_\_\_\_  
\_\_\_\_\_

(h) Qualified Mental Health Professional: \_\_\_\_\_  
(Signature)