PSYCHOLOGIST EMERGENCY EXAMINATION REQUEST
MHCC-1A Rev. 6/04
State of Connecticut
Department of Mental Health and Addiction Services
P.O. Box 341431, 410 Capitol Avenue, 4th Floor
Hartford, CT 06134

1. This form must be completed in DUPLICATE and signed by the psychologist making the request.
2. One copy must be left with the hospital and one copy returned to the psychologist.

<table>
<thead>
<tr>
<th>DIRECTIVE AND AUTHORIZATION</th>
<th>PERSON’S NAME:</th>
<th>OF: (Town in Connecticut)</th>
</tr>
</thead>
<tbody>
<tr>
<td>C.G.S. 17a-503©</td>
<td>To any proper authority: As a psychologist licensed in the State of Connecticut, I have reasonable cause to believe that the above-named person is psychiatrically disabled and dangerous to himself or herself or others, or gravely disabled, and in need of immediate care and treatment. You are therefore AUTHORIZED AND DIRECTED to take said person to: ______________________________________________________, a General Hospital, for purposes of a medical examination.</td>
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SIGNED: (Requesting Psychologist) CT LICENSE NUMBER DATE OF REQUEST
BUSINESS ADDRESS: (No. & Street, city, state, zip code) TELEPHONE NUMBER

<table>
<thead>
<tr>
<th>BUSINESS ADDRESS:</th>
<th>PERSON’S NAME:</th>
<th>OF: (Town in Connecticut)</th>
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RETURN
By virtue of the foregoing directive, I transported the above-named person to the designated General Hospital, and there entrusted said person to a duty authorized representative of said hospital.

SIGNATURE: (Proper Authority) DATE TIME am pm
HOSPITAL NAME: RECEIVED BY: (Authorized hospital representative)

TO: HOSPITAL EMERGENCY ROOM

PERSON TO BE EXAMINED: (Name) PRESENT ADDRESS:
SEX BIRTH DATE MARITAL STATUS VETERAN SOC. SEC. NO. RELIGION
NEAREST RELATIVE/FRIEND/GUARDIAN KNOWN TO THE UNDERSIGNED RELATIONSHIP TELEPHONE NO.
ADDRESS OF RELATIVE (etc.)

The relative named above HAS □ HAS NOT □ been notified of this request.

HISTORY OF PRESENT CONDITION AND REASON FOR EXAMINATION REQUEST:

OTHER PERTINENT HISTORY: (Previous hospitalizations, treatment, suicide attempts, medications, etc.)

SIGNED: (Requesting Psychologist) DATE OF SIGNATURE

<table>
<thead>
<tr>
<th>FOR HOSPITAL USE ONLY</th>
<th>CASE NUMBER</th>
<th>DISPOSITION</th>
<th>ADMISSION DATE &amp; TIME am pm</th>
<th>ADMITTED BY</th>
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