Psychotropic Medication Emergency Certification Form

#### STAMP ADDRESSOGRAPH

Emergency Certification: An emergency exists when, in the professional opinion of the prescriber, a patient presents a risk of such imminent or reasonably impending harm or danger to self or others that following the nonemergency procedures to involuntarily medicate a patient would increase risk of harm to the patient or another person.

#### I. CERTIFICATIONS AND DOCUMENTATION

A. Treatment Team Staff/RN Certification of Emergency:

his/her The patient's legal status is: \( \sigma \) vo	(name) is a patient on(state title a	(unit) and position on team	nd is under my care as n or unit).
The patient's legal status is: □ vo □ NGRI □	oluntary ☐ civilly co IST-30 ☐ IST -	ommitted $\square$ CF	EPP
The patient's clinical status and be	havior meets the above Emer.	Cert. definition, as	follows:
☐ I am familiar with the patient's supports and interventions, and the I am familiar with the patient's supports and interventions because	ey were unsuccessful in resolves safety plan; I did <u>not</u> offer	ing the emergency	(describe below).
Less restrictive alternatives considured upon the consensus of the consen	sual oral medication	r non-psychotropic	medication
☐ Patient does <u>not</u> have an advance ☐ Patient does not have an advance (no time to contact proxy; proxy no situation).	e directive that can be implem		
Patient □does □ does <u>not</u> have a	guardian, or the guardian is u	navailable.	
I, the patients' clinical situation mee	, certify that the above inforts the requirements for Emerge	mation and statemency Certification.	ents are correct and that
Signature	Date:	Time:	🗆 am 🗆 pm
Print Name			

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## **B.** Prescriber's Certification of Emergency (First Certification )

is refure psychotropic medication that, in my profession will otherwise probably result in harm to the function of the patient □ another person or persons □ I have reviewed the description of the without medication and agree that no less remedication will adequately mitigate this harm.	ising the administration of the second straight is seen as the second se	tion ofate the emergency situ to Section A above to the involuntary adr	, a short-acting ation described above that to resolve the emergency ministration of emergency
Date/time of order	Medication and do	osage	
Schedule of administration This order will need to be reviewed prior to its	s expiration on Date:	Time:	🗆 am 🗆 pm
Signature			
Print Name			
C. Nursing Documentation (First			
☐ The Prescriber conducted a face-to-face ex	amination, and he/she	wrote the above order.	
☐ I advised the patient that s/he was going to On Date: Time: ☐ Signature			
☐ First dose of medication was given: Date:	TinTinTinTinTin	me: □ a	m □ pm
Within the next 24 hours after this dose was fi	rst administered, the fo	ollowing was complete	d:
☐ Progress Notes were written every shift doc Side Effects: ☐ None Reported ☐ On Date:_ were reported to prescriber and to the Rennie A Describe negative response:	Time	🗆 am 🗆 pı	m, any negative effects the patient record.
☐ Medical Director and ☐Rennie Advocate n Time:  I,, certify t patients' clinical situation meets the requirement	otified by \(\sigma\) telephon- \(\text{a.m/pm. Date:}\) hat the above informatents for Emergency Cere	e   email at ion and statements are rtification.	correct and that the
Signature	Date:	Time:	🗆 am 🗆 pm
Print Name			

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	on of Emergency – (Second Co	ŕ		
I,	continues to refuse the administrate rofessional opinion, will mitigate	ation of the emergency situat	tice nurse, certify that, a short-acting ion described above that	
will otherwise probably result in harm  ☐ the patient ☐ another person or p				
☐ I have evaluated the patient's recoresolve the emergency and no less reswill adequately mitigate the harm. Th	strictive alternative to the involun	tary administration o		
Date/time of order	Medication and dosage			
Schedule of administration				
Signature	Date:	Time:	🗆 am 🗆 pm	
Print Name				
□ I advised the patient that s/he was a On Date: Time: Signature Time: Signature Upper the patient that s/he was a solution of the s/he was a s/he	Date: Time e was first administered, the follo shift documenting the patient's condition and print Name  Bate: Time  Time  ie Advocate and were also fully decreased.	wing was completed: ndition □ am pm, as completed in the pati	pm pm negative effects were ent record. Describe	
☐ Medical Director and ☐Rennie Addrime:  I,, patients' clinical situation meets the re	vocate notified by   telephone	□ email at		
Signature	Date:	Time:	🗆 am 🗆 pm	
Print Name				

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## F. Prescriber's Certification of Emergency (Third Certification)

I,, a ☐ conting psychotropic medication that, in my profes will otherwise probably result in harm to the ☐ the patient ☐ another person or person ☐ I have evaluated the patient's record and resolve the emergency and no less restrict will adequately mitigate the harm. The 24-	nues to refuse the administrational opinion, will mitigate are following:  Ins	ration of	, a short-acting on described above that on of medication did not
Date/time of order schedule of administration	medication and dos	age	
This order will need to be reviewed prior to	o its expiration on Date:	Time:	□ am □ pm
Signature_	Date:	Time:	🗆 am 🗆 pm
Print Name			
G. Nursing Documentation (Th  ☐ The Prescriber conducted a face-to-face  ☐ I advised the patient that s/he was going On Date: Time: Signature  ☐ First dose of medication was given: Date Signature  Within the next 24 hours after this dose was  ☐ Progress Notes were written every shift of Side Effects: ☐ None Reported ☐ On Date were reported to prescriber and to the Renn Describe negative response:	examination, and he/she wrong to be involuntarily medicated.  am pm Print Name  Time Print Name s first administered, the follodocumenting the patient's contection.  Time Advocate and were also first.	ed to resolve an emerg  am  wing was completed:  ndition  am  pm	pm, any negative effects
☐ Medical Director and ☐Rennie Advocat	te notified by \( \square \) telephone	☐ email at	
Time:, certification meets the required	a.m/pm. Date:	and statements are co	prrect and that the
Signature	Date:	Time:	🗆 am 🗆 pm
Print NameNJDHS			

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# H. Prescriber's Certification of Emergency (Fourth Certification) (only if one of the days in the 72 hours is a holiday)

,			
I,	, a □ psychiatrist; □ physicia	an;   advanced prac	tice nurse, certify that
	continues to refuse the adminis	tration of	, a short-acting
psychotropic medication that, in my	professional opinion, will mitigate	e the emergency situati	ion described above that
will otherwise probably result in ha	rm to the following:		
$\Box$ the patient $\Box$ another person $\Box$	or persons		
☐ I have evaluated the patient's re	cord and seen the patient. The first	t 24-hour administratio	on of medication did not
resolve the emergency and no less	restrictive alternative to the involu	ntary administration of	f emergency medication
will adequately mitigate the harm.	The 24-hour medication order is as	follows:	
Date/time of order			
schedule of administration			
This order will need to be reviewed	prior to its expiration on Date:	Time:	🗆 am 🗆 pm
Signature	Date:	Time:	🗆 am 🗆 pm
Print Name			
			=======================================
I Nuveing Decumentation	Founth 24 hours specied) (only if or	no of the days in the 7	2 hours is a haliday)
1. Nursing Documentation (	Fourth 24 hour preiod) (only if or	ne of the days in the 7.	2 nours is a nonday)
☐ The Prescriber conducted a face	-to-face examination, and he/she w	rote the above order.	
☐ I advised the patient that s/he wa	as going to be involuntarily medicate	ted to resolve an emerg	ency.
On Date: Time:	□ am □ pm	Č	,
On Date: Time: Signature	Print Name		
☐ First dose of medication was give	en: Date: Time	e: 🗆 am	□ pm
☐ First dose of medication was give Signature	Print Name		
Within the next 24 hours after this c	lose was first administered, the following	owing was completed:	
Drograss Notes were written aver	ay shift documenting the nationt's a	andition	
☐ Progress Notes were written even			any nagative affacts
Side Effects: ☐ None Reported ☐	On Date Time	fully documented in the	, any negative effects
were reported to prescriber and to the	ne Rennie Advocate and were also	rully documented in the	e patient record.
Describe negative response:			
T Madical Discrete and TD and	Advanta matical bar D. Advalanta	T:1 -4	
☐ Medical Director and ☐ Rennie A	Advocate notified by Litelephone a m/nm. Date:	□ email at	
I mic	certify that the above information	n and statements are co	orrect and that the
Time:	requirements for Emergency Certi	fication.	freet and that the
Signature	Date:	Time:	🗆 am 🗆 pm
Print Name			
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#### II. 72-HOUR ADMINISTRATIVE REVIEW

#### A. Medical/Clinical Director or Chief of Psychiatry

Instructions: Shall be completed by the Medical/Clinical Director or Chief of Psychiatry, unless unavailable, When these individuals are unavailable, and when more than one prescriber is on duty, a prescriber who is not assigned to the patient will review the emergency. If the event takes place when the Medical/Clinical Director, Chief of Psychiatry and Acting Medical/Clinical Director and all non-treating prescribers are unavailable, and they continue to be unavailable for the entire 72-hour period after the first administration of emergency medication, the review will

be conducted by the building nursing super		ration of emergency me	dication, the review will
Review conducted by:	, Title		
After conducting a face-to-face evaluation the patient record, I conclude the following		ng the prescriber's eme	ergency certification and
☐ Administration of emergency medication another person was imminent or reasonably ☐ The prescriber based his or her profession to avoid the emergency administration of m ☐ The prescriber should have initiated the orders:	y impending, onal judgment on best or enedication were made. e following interventions, i	effective practices, and n addition to, or in place	all reasonable efforts
Signature	Date:	Time:	🗆 am 🗆 pm
Print Name			
☐ All steps of emergency administration ☐ Emergency medication was limited including holidays)	ed to 72 hours or less	ved. (including Saturday	s/Sundays but not
The following problems in the pro- report to the CEO, Medica			Medical Director:
Outcome  ☐ Medication discontinued ☐ Medicat ☐ Medication continued, 3 step proces ☐ Other:	ss initiated	n continued, FI proces	ss initiated
Signature	Date:	Time:	🗆 am 🗆 pm
Print Name			
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