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:

____________________________ (name) is a patient on ______________ (unit) and is under my care as his/her ______________________ (state title and position on team or unit).

The patient’s legal status is: ☐ voluntary ☐ civilly committed ☐ CEPP
☐ NGRI ☐ IST-30 ☐ IST -90

The patient’s clinical status and behavior meets the above Emer. Cert. definition, as follows:

☐ I am familiar with the patient’s safety plan; I have offered the patient his or her preferred behavioral supports and interventions, and they were unsuccessful in resolving the emergency (describe below).

☐ I am familiar with the patient’s safety plan; I did not offer the patient his or her preferred behavioral supports and interventions because (describe below):

Less restrictive alternatives considered and rejected, or attempted, without success:
☐ verbal de-escalation ☐ consensual oral medication ☐ other non-psychotropic medication
☐ other (describe):

☐ Patient does not have an advance directive.
☐ Patient does not have an advance directive that can be implemented in time to resolve the emergency (no time to contact proxy; proxy not available, instructions inapplicable or unsuccessful in resolving situation).

Patient ☐ does ☐ does not have a guardian, or the guardian is unavailable.

I, ____________________________, certify that the above information and statements are correct and that the patients’ clinical situation meets the requirements for Emergency Certification.

Signature________________________________ Date: ____________ Time: ____________ ☐ am ☐ pm

Print Name______________________________________
B. Prescriber’s Certification of Emergency (First Certification)

I, ____________________________, a ☐ psychiatrist; ☐ physician; ☐ advanced practice nurse, certify that ___________________________ is refusing the administration of ________________, a short-acting psychotropic medication that, in my professional opinion, will mitigate the emergency situation described above that will otherwise probably result in harm to the following:
☐ the patient ☐ another person or persons ☐ both.
☐ I have reviewed the description of the efforts made pursuant to Section A above to resolve the emergency without medication and agree that no less restrictive alternative to the involuntary administration of emergency medication will adequately mitigate this harm. The 24-hour medication order is as follows:

Date/time of order _______________________ Medication and dosage __________________________
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________________________________

C. Nursing Documentation (First 24 hour period)

☐ The Prescriber conducted a face-to-face examination, and he/she wrote the above order.

☐ I advised the patient that s/he was going to be involuntarily medicated to resolve an emergency.

On Date: ___________ Time: ___________ ☐ am ☐ pm

Signature_________________________________ Print Name________________________________

☐ First dose of medication was given: Date: ___________ Time: ___________ ☐ am ☐ pm

Signature_________________________________ Print Name________________________________

Within the next 24 hours after this dose was first administered, the following was completed:

☐ Progress Notes were written every shift documenting the patient’s condition

Side Effects: ☐ None Reported ☐ On Date: ___________ Time: ___________ ☐ am ☐ pm, any negative effects were reported to prescriber and to the Rennie Advocate and were also fully documented in the patient record.

Describe negative response:
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

☐ Medical Director and ☐ Rennie Advocate notified by ☐ telephone ☐ email at

Time: ___________ a.m./p.m. Date: ___________

I, ____________________________, certify that the above information and statements are correct and that the patients’ clinical situation meets the requirements for Emergency Certification.

Signature_________________________________ Date: ___________ Time: ___________ ☐ am ☐ pm

Print Name_________________________________
D. Prescriber’s Certification of Emergency – (Second Certification):

I, ____________________________, a ☐ psychiatrist; ☐ physician; ☐ advanced practice nurse, certify that ____________________________ continues to refuse the administration of ________________, a short-acting psychotropic medication that, in my professional opinion, will mitigate the emergency situation described above that will otherwise probably result in harm to the following:
☐ the patient  ☐ another person or persons  ☐ both.

☐ I have evaluated the patient’s record and seen the patient. The first 24-hour administration of medication did not resolve the emergency and no less restrictive alternative to the involuntary administration of emergency medication will adequately mitigate the harm. The 24-hour medication order is as follows:

Date/time of order ______________________ Medication and dosage_________________________
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__________________________________

E. Nursing Documentation (Second 24 hour period)

☐ The Prescriber conducted a face-to-face examination, and he/she wrote the above order.

☐ I advised the patient that s/he was going to be involuntarily medicated to resolve an emergency.

On Date: ___________ Time:___________ ☐ am ☐ pm

Signature____________________________________  Print Name __________________________

☐ First dose of medication was given: Date:_________________ Time:___________ ☐ am ☐ pm

Signature____________________________________  Print Name __________________________

Within the next 24 hours after this dose was first administered, the following was completed:

☐ Progress Notes were written every shift documenting the patient’s condition
Side Effects: ☐ None Reported  ☐ On Date: ___________ Time ___________ ☐ am ☐ pm, any negative effects were reported to prescriber and to the Rennie Advocate and were also fully documented in the patient record. Describe negative response:

______________________________________________________________________________________________

Medical Director and ☐ Rennie Advocate notified by ☐ telephone  ☐ email at
Time: ___________________ a.m./p.m. Date:

I, ____________________________, certify that the above information and statements are correct and that the patients’ clinical situation meets the requirements for Emergency Certification.

Signature____________________________________  Date: ____________ Time:______________ ☐ am ☐ pm

Print Name______________________________
F. Prescriber’s Certification of Emergency (Third Certification)

I, ____________________________, a ☐ psychiatrist; ☐ physician; ☐ advanced practice nurse, certify that ___________________________ continues to refuse the administration of ________________, a short-acting psychotropic medication that, in my professional opinion, will mitigate the emergency situation described above that will otherwise probably result in harm to the following:
☐ the patient ☐ another person or persons ☐ both.
☐ I have evaluated the patient’s record and seen the patient. The first 24-hour administration of medication did not resolve the emergency and no less restrictive alternative to the involuntary administration of emergency medication will adequately mitigate the harm. The 24-hour medication order is as follows:

Date/time of order __________________________medication and dosage_________________________
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__________________________________

G. Nursing Documentation (Third 24 hour period)

☐ The Prescriber conducted a face-to-face examination, and he/she wrote the above order.

☐ I advised the patient that s/he was going to be involuntarily medicated to resolve an emergency.
On Date: ___________ Time:_____________ ☐ am ☐ pm
Signature______________________________    Print Name _________________________________

☐ First dose of medication was given: Date:_________________ Time:___________ ☐ am ☐ pm
Signature _____________________________    Print Name___________________________________

Within the next 24 hours after this dose was first administered, the following was completed:

☐ Progress Notes were written every shift documenting the patient’s condition
Side Effects: ☐ None Reported ☐ On Date:_____________ Time_____________ ☐ am ☐ pm, any negative effects were reported to prescriber and to the Rennie Advocate and were also fully documented in the patient record.
Describe negative response:
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

☐ Medical Director and ☐ Rennie Advocate notified by ☐ telephone ☐ email at
Time: ____________________________ a.m./p.m. Date:
I, ____________________________, certify that the above information and statements are correct and that the patients’ clinical situation meets the requirements for Emergency Certification.

Signature____________________________________  Date: ____________ Time:_____________ ☐ am ☐ pm
Print Name__________________________________
H. Prescriber’s Certification of Emergency (Fourth Certification) (only if one of the days in the 72 hours is a holiday)

I, ____________________________, a ☐ psychiatrist; ☐ physician; ☐ advanced practice nurse, certify that __________________________ continues to refuse the administration of __________________________, a short-acting psychotropic medication that, in my professional opinion, will mitigate the emergency situation described above that will otherwise probably result in harm to the following:
☐ the patient ☐ another person or persons ☐ both.
☐ I have evaluated the patient’s record and seen the patient. The first 24-hour administration of medication did not resolve the emergency and no less restrictive alternative to the involuntary administration of emergency medication will adequately mitigate the harm. The 24-hour medication order is as follows:

Date/time of order __________________________ medication and dosage __________________________ 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. Nursing Documentation (Fourth 24 hour period) (only if one of the days in the 72 hours is a holiday)

☐ The Prescriber conducted a face-to-face examination, and he/she wrote the above order.

☐ I advised the patient that s/he was going to be involuntarily medicated to resolve an emergency.
On Date: ___________ Time: ___________ ☐ am ☐ pm
Signature____________________________________  Print Name________________________

☐ First dose of medication was given: Date: ___________ Time: ___________ ☐ am ☐ pm
Signature____________________________________  Print Name________________________

Within the next 24 hours after this dose was first administered, the following was completed:

☐ Progress Notes were written every shift documenting the patient’s condition
Side Effects: ☐ None Reported ☐ On Date: ___________ Time: ___________ ☐ am ☐ pm, any negative effects were reported to prescriber and to the Rennie Advocate and were also fully documented in the patient record.
Describe negative response:
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

☐ Medical Director and ☐ Rennie Advocate notified by ☐ telephone ☐ email at
Time: ___________________________ a.m./p.m. Date: ___________
I, ____________________________, certify that the above information and statements are correct and that the patients’ clinical situation meets the requirements for Emergency Certification.

Signature____________________________________  Date: ____________ Time: ___________ ☐ am ☐ pm
Print Name__________________________________
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 supervisor.

Review conducted by: ___________________________________, Title ____________________

After conducting a face-to-face evaluation of the patient and reviewing the prescriber’s emergency certification and the patient record, I conclude the following:

☐ Administration of emergency medication ☐ was ☐ was not appropriate because danger to the patient or another person was imminent or reasonably impending.
☐ The prescriber based his or her professional judgment on best or effective practices, and all reasonable efforts to avoid the emergency administration of medication were made.
☐ The prescriber should have initiated the following interventions, in addition to, or in place of, his/her medication orders: ____________________________________

_________________________________________  Date: ___________  Time: ___________  ☐ am  ☐ pm
Print Name ________________________________________________

B. Rennie Advocate Review
☐ , Rennie Advocate, ☐ Reviewed chart on Date: ________  Time: ________
☐ All steps of emergency administration procedure were followed.
☐ Emergency medication was limited to 72 hours or less (including Saturdays/Sundays but not including holidays)
☐ The following problems in the procedure were noted in the chart and communicated in my monthly report to the CEO, Medical/Clinical Director, and DMHAS Medical Director:

__________________________________________________________

Outcome
☐ Medication discontinued  ☐ Medication continued, patient consenting
☐ Medication continued, 3 step process initiated  ☐ Medication continued, FI process initiated
☐ Other: ____________________________________________________________

_________________________________________  Date: ___________  Time: ___________  ☐ am  ☐ pm
Print Name ________________________________________________