

PROBATE COURT OF PORTAGE COUNTY, OHIO
PATRICIA J. SMITH, JUDGE

IN THE MATTER OF: _____

CASE NO. _____

CERTIFICATE OF EXAMINATION

[R.C. 5122.111]

Patient's Name	Age	Sex	Race	Date of Birth	Marital Status

Patient's Address:

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Street

City

State

ZIP

The undersigned certifies that he/she is a:

psychiatrist licensed clinical psychologist or licensed physician of the State of Ohio, and that the following are facts relating to the examination of the above-named person.

I further certify:

1. That I have with care and diligence personally observed and examined the above-named person on _____, and;
2. That said person was examined at _____ (place of examination) and as a result of such examination, I believe that said person
 is mentally ill and subject to Court order
(or)
 is not mentally ill and subject to Court order

DIAGNOSIS AND RECOMMENDED TREATMENT:

[Please indicate the physical or mental health condition needing immediate treatment and the recommended method of treatment (hospitalization and/or outpatient treatment)]

[Attach additional information if necessary]
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I further certify that:

[Please check the appropriate box(s):]

- Represents a substantial risk of physical harm to self as manifested by evidence of threats of, or attempts at, suicide or serious self-inflicted bodily harm;
- Represents a substantial risk of physical harm to others as manifested by evidence of recent homicidal or other violent behavior, evidence of recent threats that place another in reasonable fear of violent behavior and serious physical harm or other evidence of present dangerousness;
- Represents a substantial and immediate risk of serious physical impairment or injury to self as manifested by evidence that the person is unable to provide for and is not providing for the person's basic physical needs because of the person's mental illness and that appropriate provision for those needs cannot be made immediately available in the community;
- Would benefit from treatment for mental illness and is in need of such treatment as manifested by evidence of behavior that creates a grave and imminent risk to substantial rights of others or the person; or

NOTE: An individual who meets only the criteria described in the box below is not subject to hospitalization and is only subject to Assisted Outpatient Treatment.

- Would benefit from treatment as manifested by evidence of behavior that indicates all of the following:
 - a. The person is unlikely to survive safely in the community without supervision, based on clinical determination.
 - b. The person has a history of lack of compliance with treatment for mental illness and one of the following applies:
 - i. At least twice within the thirty-six months prior to the filing of an affidavit seeking court-ordered treatment of the person under section 5122.111 of the Revised Code, the lack of compliance has been a significant factor in necessitating hospitalization in a hospital or receipt of services in a forensic or other mental health unit of a correctional facility, provided that the thirty-six month period shall be extended by the length of any hospitalization or incarceration of the person that occurred within the thirty-six month period.
 - ii. Within the forty-eight months prior to the filing of an affidavit seeking court-ordered treatment of the person under section 5122.111 of the Revised Code, the lack of compliance resulted in one or more acts of serious violent behavior towards self or others or threats of, or attempts at, serious physical harm to self or others, provided that the forty-eight month period shall be extended by the length of any hospitalization or incarceration of the person that occurred within the forty-eight-month period.
 - c. The person as a result of mental illness, is unlikely to voluntarily participate in necessary treatment.
 - d. In view of the person's treatment history and current behavior, the person is in need of treatment in order to prevent a relapse or deterioration that would be likely to result in substantial risk of serious harm to the person or others.

Examiner's Signature

Title

Printed Name

License Number

Address

Phone Number

City, State, ZIP