Baker Act

Selected Forms

6th Judicial Circuit
January 18, 2019

Certificate of Professional Initiating Involuntary Examination

ALL SECTIONS OF THIS FORM MUST BE COMPLETED AND LEGIBLE (PLEASE PRINT)

I have personally examined (printed name of person) ________________________ at (time________ ☐ am ☐ pm (time must be within the preceding 48 hours) on (date) ____________in ________________ county and said person appears to meet the criteria for involuntary examination.

☐ CHECK HERE if you are a physician certifying non-compliance with an involuntary outpatient placement order and you are initiating involuntary examination. (If so, person examination within preceding 48 hours is not required. However, please provide documentation of efforts to solicit compliance in Section IV on page 2 of this form.)

This is to certify that my professional license number is: ____________________ and I am a licensed (check one box):
]
☐ Psychiatrist ☐ Physician (but not a psychiatrist) ☐ Clinical Psychologist ☐ Psychiatric Nurse
☐ Clinical Social Worker ☐ Mental Health Counselor ☐ Marriage and Family Therapist ☐ Physician's Assistant

Section I: CRITERIA

1. There is reason to believe said person has a mental illness as defined in section 394.455, Florida Statutes.

"Mental illness" means an impairment of the mental or emotional processes that exercise conscious control of one's actions or of the ability to perceive or understand reality, which impairment substantially interferes with the person's ability to meet the ordinary demands of living. For the purposes of this part, the term does not include a developmental disability as defined in chapter 393, intoxication, or conditions manifested only by antisocial behavior or substance abuse impairment.

Diagnosis of Mental Illness is: List all mental health diagnoses applicable to this person		DSM Code(s) (if known)

AND because of the mental illness (check all that apply):

☐ a. Person has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination; **AND/OR**

☐ b. Person is unable to determine for himself/herself whether examination is necessary; **AND**

2. Either (check all that apply):

☐ a. Without care or treatment, the person is likely to suffer from neglect or refuse to care for himself or herself; such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services; or

☐.b. There is a substantial likelihood that without care or treatment the person will cause serious bodily harm to (check one or both) ☐ **self** ☐ **others** in the near future, as evidenced by recent behavior

Section II: SUPPORTING EVIDENCE

Observations supporting these criteria are (including evidence of recent behaviors related to criteria). Please include the person's behaviors and statements, including those specific to suicidal ideation, previous suicide attempts, homicidal ideation or self-injury.:

Certificate of Professional Initiating Involuntary Examination

Section III: Other Information

Other information, including source relied upon to reach this conclusion is as follows. If information is obtained from other persons, describe these sources (e.g., reports of family, friends, other mental health professionals or law enforcement officers, as well as medical or mental health records, etc.).

Section IV: NON-COMPLIANCE WITH INVOLUNTARY OUTPATIENT PLACEMENT ORDER

Complete this section if you are a physician who is documenting non-compliance with an involuntary outpatient placement order: This is to certify that I am a physician, as defined in Florida Statutes 394.455), F.S. and in my clinical judgment, the person has failed or has refused to comply with the treatment ordered by the court, and the following efforts have been made to solicit compliance with the treatment plan:

Section V: INFORMATION FOR LAW ENFORCEMENT

Provide identifying information (if known) if needed by law enforcement to find the person so he/she may be taken into custody for examination:

Age: __________ ☐ Male ☐ Femal Race/ethnicity: ______________________

Other details (such as height, weight, hair color, clothing worn when last seen, where last seen):

If relevant, information such as access to weapon, recent violence or pending criminal charges:

This form must be transported with the person to the receiving facility to be retained in the clinical record. Copies may be retained by the initiating professional and by the law enforcement agency transporting the person to the receiving facility.

Section VI: SIGNATURE

____ ____________________ ____ ☐am ☐ pm

Signature of Professional: Date Signed _Time

____

By Authority of Rule 65E-5.260, F.A.C.
CF-MH 3052b,Jun 2016 (Mandatory Form)

Report of Law Enforcement Officer Initiating Involuntary Examination
State of Florida, County of ____________________, Florida

I,____, am a law enforcement officer certified by the State of Florida. In my opinion

____ appears to meet the following criteria for involuntary examination:

1. I have reason to believe said person has a mental illness pursuant to Section 394.455 (18), F.S., and because of the mental illness (check a or b):

   ☐ a. Person has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination; **OR**

   ☐ b. Person is unable to determine for himself/herself whether examination is necessary, **AND**

2. Either (check all that apply)

   ☐ a. Without care or treatment said person is likely to suffer from neglect or refuse to care for himself/herself, and such neglect or refusal poses a real and present threat of substantial harm to his/her well-being and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services; AND/**OR**,

   ☐ b There is substantial likelihood that without care or treatment the person will cause serious bodily harm to (check one or both) ☐**self** ☐**others** in the near future, as evidenced by recent behavior.

Circumstances supporting this opinion, including specific information about the person's behavior, threats and actions and information offered by others:

____

____

____

____

____

_____________________________ Signature of Law Enforcement Officer

_______ / _______ / 20_______

_______ am pm
Time

_____________________________ Printed Name of Law Enforcement Officer

_____________________________ Full Name of Law Enforcement Agency (printed)

_____________________________ Badge or ID Number

_____________________________ Law Enforcement Case Number

a. Has the law enforcement officer initiating this examination completed a 40-hour Crisis Intervention Training program? ☐ yes ☐ no

b. Has the law enforcement officer initiating this examination completed the Baker Act training offered through FMHI? ☐ yes ☐ no

c. Was the examination initiated in the officer's capacity as a school resource officer? ☐ yes ☐ no

d. Does the person have a drug or alcohol involvement **in addition to a mental illness** (does not disqualify for Baker Act admission)

☐ yes ☐ no ☐ unknown

By Authority of s. 394.463(2)(a) 2, Florida Statutes
CF-MH 3052a, Feb 05 (obsoletes previous editions) (Mandatory Form)

BAKER ACT

IN THE CIRCUIT COURT OF THE ________ JUDICIAL CIRCUIT

IN AND FOR ______________________ COUNTY, FLORIDA

IN RE: ________________________ CASE NO.: ______________________

Petition and Affidavit Seeking Ex Parte Order Requiring Involuntary Examination

I, ________________________________, being duly sworn, am filing this sworn statement requesting a court order for the
Print Name of Petitioner
involuntary examination of ____ (hereinafter referred to as PERSON).
Print Name of Person

This petition and affidavit will be included in the PERSON's clinical record and may be viewed by the PERSON.

I understand that by filling out this form, the PERSON may be taken by law enforcement to a mental health facility for an examination.

I SWEAR that the answers to the following questions are given honestly, in good faith, and to the best of my knowledge.

1. a. I live at: (Print Your Full Residence Address and Phone Number) Phone: (_____) ____________________

   Street Address: ______________________________________ City ____________ ST ____ Zip______

   b. I work as a: (Occupation) ______________________________ Work Phone: (_____) __________

   Work Street Address: ______________________________________ City ____________ ST ____ Zip ______

   c. The PERSON lives at, or may be found at, the following address(es):

   Street Address: ____ City ____________

   Street Address: ____ City ____________

   Street Address: ____ City ____________

2. I have the following relationship with the PERSON: ____

   ____

3. (Check the one box that applies)

   ☐ a. I or a family member ☐ have or ☐ have not previously made allegations to law enforcement involving this PERSON on ___________ (Date) such as domestic violence, trespassing, battery, child abuse or neglect, Baker Act, neighborhood disputes, etc. as described: ____

   ____

   ____

   ☐ b. This PERSON ☐ has or ☐ has not previously made allegations to law enforcement about me or my family on ____________ (Date) such as domestic violence, trespassing, battery, child abuse or neglect, Baker Act, etc. as described: ____

   ____

CONTINUED OVER

4. (Check the one box that applies)
   - ☐ a. I or a family member are not now, and have not in the past, been involved in a court case with the PERSON.
   - ☐ b. I or a family member am now, or was, involved in a court case with the PERSON. This case is/was a

   ______________________________ in ______________________
   Type of Case   When

   Explain: ____

   ____

5. I am on good terms with the PERSON at the present time. (Check one box) ☐ Yes ☐ No If "no", please explain:

   ____

   ____

6. I have known the PERSON for ____________________ (how long).
   - ☐ a. The PERSON has only recently displayed unusual kinds of behavior.
   - ☐ b. The PERSON has, over a period of time, always acted in a strange manner.
   - ☐ c. The PERSON's behavior has developed over a period of time.

COMPLETE THE FOLLOWING ONLY IF THE SECTION APPLIES TO THIS CASE:

7. I have seen the following behavior, which causes me to believe that there is a good chance that the PERSON will cause serious bodily harm to himself/herself or others. On ______________ at approximately ____________ am pm,
   Date   Time

   I saw the PERSON: ____

   ____

   ____

8. Other similar behavior I have personally seen is as follows: ____

   ____

   ____

   ____

9. ☐ To my knowledge or belief, ☐ I do ☐ I do not believe these actions were a result of retardation, developmental disability, intoxication, or conditions resulting from antisocial behavior or substance abuse impairment.

CHECK AND/OR ANSWER APPLICABLE SECTIONS

10. ☐ a. I have attempted to get the PERSON to agree to seek assistance for a mental or emotional problem(s). I explained the purpose of the examination (describe when, who was present, and whether you or another person explained the need for the examination): ____

    ____

    ____

    ☐ b. I did not try to get the PERSON to agree to a voluntary examination because: ____

    ____

    ☐ c. The PERSON refused a voluntary examination because: ____

    ____

CONTINUED

11. The following steps were taken to get the PERSON to go to a hospital for mental health care: ____________

____

____

____

These steps did not work because: ____________

____

____

12. I believe that the PERSON is unable to determine for himself/herself, why the examination is necessary because:

____

____

____

13. I believe that the PERSON has a mental illness which will keep the PERSON from being able to meet the ordinary demands of living because: ____________

____

____

____

14. I believe that without care or treatment, the PERSON is likely to suffer from neglect or refuse to care for himself/ herself, because: ____________

____

____

15. I believe that this lack of care or neglect will lead to the PERSON hurting himself or herself because:

____

____

____

16. Can family or close friends now provide enough care to avoid harm to the PERSON? ☐ Yes ☐ No, If not, why?

____

____

____

____

CONTINUED OVER

Petition and Affidavit Seeking Ex Parte Order Requiring Involuntary Examination (Page 4)

Provide the following identifying information about the person (if known) if it is determined necessary to take the person into custody for examination:

County of Residence: Age:

Sex : ☐ Male ☐ Female Race: Attach a picture of the PERSON if possible. Picture attached: ☐ No ☐ Yes

Height: Weight: Hair Color: Eye Color:

Does the PERSON have access to any weapons? ☐ No ☐ Yes If yes, describe:

Is the PERSON violent now? ☐ No ☐ Yes Has the person been violent in the recent past? ☐ No ☐ Yes If Yes, Describe:

Does the PERSON have any pending criminal charges against him/her? ☐ No ☐ Yes If yes, describe:

GUARDIANSHIP:

1) Does the PERSON have a legal guardian? ☐ No ☐ Yes

2) Is there a pending petition to determine the PERSON's capacity and for the appointment of a guardian? ☐ No ☐ Yes
If YES to either of the above, provide the name, address and phone number of the current or proposed guardian.

Name: ______________________ Phone: (________) ______________

Address: ______________________ City: ______________ Zip: ________

____

PHYSICIAN: Name: Phone: (   )

MEDICATIONS: Provide name of medications if known.

CASE MANAGEMENT: Provide name and phone number of case manager or case management agency, if known.

I understand that this sworn statement is given under oath and will be treated as though it was made before a judge in a court of law. I understand that any information in this sworn statement which is not to the best of my knowledge and done in good faith may expose me to a penalty for perjury and other possible penalties under the statutes of the State of Florida.

Under penalties of perjury, I declare that I have read the foregoing document and that the facts stated in it are true.

Signature of Affiant/Petitioner: ______________________________

SWORN TO AND SUBSCRIBED before me

this ________ day of ____________________, ____________
Day Month Year

by ______________________________ who is personally known

to me or presented ______________________ as identification.

____
Notary Public - State of Florida

My Commission expires: Date______________

OR

SWORN TO AND SUBSCRIBED before me

this ________ day of ____________________, ____________
Day Month Year

Clerk of Circuit Court

______________________ County, Florida

By: ______________________________
Deputy Clerk

A copy of the petition(s) must be attached to an Ex Parte Order for Involuntary Examination and accompany the person to the nearest receiving facility.

See s. 394.463, Florida Statutes

IN THE CIRCUIT COURT OF THE ______________ JUDICIAL CIRCUIT

IN AND FOR __________________________ COUNTY, FLORIDA

IN RE: ____ CASE NO.: _________________________

Ex Parte Order for Involuntary Examination

Pursuant to Section 394.463(2)(a)1, Florida Statutes, this Court having received sworn testimony, states that the above-named person, presently within the county, appears to meet the following criteria for involuntary examination:

1. There is reason to believe the above-named person has a mental illness as defined in Section 394.455 (18), F.S., and because of this mental illness said person:
   - ☐ (a) has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination; **or**
   - ☐ (b) is unable to determine for himself/herself whether examination is necessary, **AND**

2. Either (Check a and/or b)
   - ☐ (a) without care or treatment the above-named person is likely to suffer from neglect or refuse to care for himself/herself, and such neglect or refusal poses a real and present threat of substantial harm to his or her well-being and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services; **OR**
   - ☐ (b) There is substantial likelihood that without care or treatment the above-named person will cause serious bodily harm to ☐ himself or herself or ☐ another person in the near future, as evidenced by recent behavior.

One or more Petitions and Affidavits Seeking Order Requiring Involuntary Examination (CF-MH 3002 or equivalent) on which the above conclusion is based is attached.

Additional information upon which this order is based is: ____

____

____

Therefore, it is

ORDERED

That a law enforcement officer, or designated agent of the Court take the above-named person into custody and deliver or arrange for the delivery of said person to the **nearest** receiving facility for involuntary examination, and that this order and petition be made part of said person's clinical record. A law enforcement officer or agent may serve and execute this order on any day of the week, at any time of the day or night. A law enforcement officer or agent may use such reasonable physical force as is necessary to gain entry to the premises, and any dwellings, buildings, or other structures located on the premises, and to take custody of the person who is the subject of this ex parte order.

This order expires in ___________ days. If no time limit is specified in this order, the order shall be valid for 7 days after the date that the order was signed.

ORDERED THIS ___________ day of ___________________________, ___________
Date Month Year

_______________________________ _______________________________
Printed Name of Circuit Court Judge Signature of Circuit Court Judge

See s. 394.463, Florida Statutes
CF-MH 3001, Jan 98 (obsoletes previous editions) (Recommended Form)

BAKER ACT

IN THE CIRCUIT COURT OF THE __________ JUDICIAL CIRCUIT

IN AND FOR ____________________________ COUNTY, FLORIDA

IN RE: ____ CASE NO.: ____________________________

Petition for Involuntary Inpatient Placement

COMES NOW the Petitioner, ____, and alleges:

1. That Petitioner is Administrator of ____________________________ ____________________________________
   Name of Facility Facility Address

2. That (Name of Person) ____, is a patient of said facility and has been examined at such facility.

3. The person's social security number is __________________________ and date of birth is: ____________________.
   Date

4. That this petition is being filed within the following time frames: (Check one below)

   ☐ A. This person was admitted for involuntary examination and this petition is being filed within the 72-hour examination period, or if the examination period ends on a weekend or legal holiday, on the next court working day
   OR

   ☐ B. This person was transferred to involuntary status after examination or after refusing/revoking consent to treatment or requesting discharge from the facility and this petition is filed within two court working days.

5. That attached hereto and by reference made a part hereof, are two (2) opinions regarding the mental health of said person necessitating involuntary inpatient placement.

6. That based thereon Petitioner recommends that the person/respondent be involuntarily placed in
   ____, a (public/private) designated receiving or treatment facility.

7. In addition to at least one of the two experts whose opinions are attached, the following persons may testify:

	Guardian or Representative	**Other Witness**	**Other Witness**
Name:	________________________	________________________	________________________
Relationship	________________________	________________________	________________________
Address	________________________	________________________	________________________
	________________________	________________________	________________________
Telephone:	(_____)________________	(_____)________________	(_____)________________

CONTINUED OVER

Petition for Involuntary Placement (Page 2)

COMES NOW THE PETITIONER and further alleges that:

☐ 1. A Guardian Advocate is necessary to act on the person's behalf on issues related to express and informed consent to mental health or medical treatment and a Petition for Adjudication of Incompetence to Consent to Treatment and Appointment of a Guardian Advocate is attached; OR

☐ 2. The person/respondent is competent to provide express and informed consent to his or her own treatment or the person has a guardian authorized to consent to treatment and no Guardian Advocate is requested.

______________________________ Signature of Facility Administrator or Designee

________________ Date

__________ am pm Time

______________________________ Typed or Printed Name of Administrator or Designee

The person ☐ does or ☐ does not have a private attorney. If so, the name and address of the private attorney is:

Private Attorney Name: ______________________________

Private Attorney Address: ______________________________

cc: The Clerk of the Court shall provide a copy of this petition to the: (Check when applicable and initial/date/time when copy provided)

Individual	Date Copy Provided	Time Copy Provided	Initials of Who Provided Copy
☐ Person		am pm	
☐ Guardian		am pm	
☐ Public Defender		am pm	
☐ Representative		am pm	
☐ State Attorney		am pm	
☐ Dept. of Children & Families		am pm	

CONTINUED / SUPPORTING OPINIONS ON PAGE 3

Petition for Involuntary Placement (Page 3)

First Opinion Supporting the Petition

I, ______________________________ a psychiatrist authorized to practice in the State of Florida, have personally examined ______________________________ on ______________ (within 72 hours of the signing hereof) and find from such
Name of Person Date
examination that the person meets the following criteria for involuntary placement:

1. Said person is mentally ill and because of a mental illness (check one):
   - ☐ a. Said person has refused voluntary placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of placement for treatment; OR
   - ☐ b. Said person is unable to determine for himself/herself whether placement is necessary:

AND

2. Either (Check one or both):
   - ☐ a. Said person is manifestly incapable of surviving alone or with the help of willing and responsible family or friends, including available alliterative services, and without treatment, he/she is likely to suffer from neglect or refuse to care for himself/herself and such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; OR
   - ☐ b. There is substantial likelihood that in the near future said person will inflict serious bodily harm on himself/herself or another person as evidenced by recent behavior causing, attempting, or threatening such harm.

AND

All available less restrictive treatment alternatives which would offer an opportunity for improvement of said person's condition have been judged to be inappropriate based on contact with the following programs/agencies: ______________________________
____

Observations which support this opinion are:

______________________________ ______________ ______________ am pm
Signature of Psychiatrist Date Time

______________________________ ______________________
Typed or Printed Name of Psychiatrist License Number

Second Opinion Supporting the Petition

I, ______________________________, a ☐ psychiatrist, ☐ clinical psychologist, ☐ licensed physician *, ☐ psychiatric nurse *, authorized to provide a second opinion on this petition pursuant to Section 394.467 (2), F.S., have personally examined ______________________________ on ______________, (within 72 hours of signing hereof), and
Name of Person Date
find that he/she meets the criteria for involuntary inpatient placement as stated in this petition. Observations which support this opinion are:

______________________________ ______________ ______________ am pm
Signature of Examiner Date Time

______________________________ ______________ ______________
Typed or Printed Name of Examiner Profession License Number

I certify that the county in which the person is detained has less than 50,000 population and no psychiatrist or psychologist is available to provide the second opinion.

______________________________ ______________
Printed Name and Signature of Administrator or Designee Date

*** A licensed physician or psychiatric nurse may only provide such second opinion in counties of less than 50,000 population in cases where the facility administrator certifies that no psychiatrist or clinical psychologist is available to provide the second opinion (by countersigning above).**

See s. 394.4599(2)(c)3, 394.467, Florida Statutes
CF-MH 3032, Feb 05 (obsoletes previous editions) (Recommended Form)

BAKER ACT

IN THE CIRCUIT COURT OF THE __________ JUDICIAL CIRCUIT

IN AND FOR ___________________________ COUNTY, FLORIDA

IN RE: ___________________________________ CASE NO.: __________________________

Order for Involuntary Inpatient Placement

This matter came to be heard pursuant to a Petition for Involuntary Inpatient Placement filed herein on the issue of whether the above-named person should be involuntarily placed in a mental health treatment or receiving facility, and the Court being fully advised in the premises, finds by clear and convincing evidence, as follows:

1. Said person has been represented by counsel; Said person ☐ appeared at the hearing, or ☐ said person's presence at the hearing was waived, without objection of said person's counsel.

2. Said person meets the following criteria for involuntary inpatient placement pursuant to s. 394.467(1), F.S. :
   (a) He or she is mentally ill and because of a mental illness:
      (1) has refused voluntary placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of placement for treatment; or
      (2) is unable to determine for himself or herself whether placement is necessary; **AND**
   (b) Either
      (1) He or she is manifestly incapable of surviving alone or with the help of willing and responsible family or friends, including available alternative services, and, without treatment, is likely to suffer from neglect or refuse to care for himself or herself, and such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; or
      (2) There is substantial likelihood that in the near future he or she will inflict serious bodily harm on himself or herself or another person, as evidenced by recent behavior causing, attempting, or threatening such harm; and
   (c) All available less restrictive treatment alternatives which would offer an opportunity for improvement of his or her condition have been judged to be inappropriate.

3. The nature and extent of the above-named person's mental illness is as follows:

____

____

4. The Court considered testimony and evidence regarding the person's competence to consent to treatment. The person was found to be
☐ competent ☐ incompetent to consent to treatment. If found to be incompetent, ______________________________
____ was appointed as guardian advocate.
(name and address)

5. If the petition was referred to and heard by a general master, the Master's Report and Recommendation are attached, incorporated by reference, and/or adopted by the Court.

ORDERED

That the above-named person be placed in a designated mental health receiving or treatment facility on an involuntary basis for a period of up to ___________________________, not to exceed 6 months from the date of this order, or until discharged by the administrator or transferred to voluntary status.

DONE AND ORDERED in __________________ County, Florida, this ______ day of __________________, ________

_______________________________ _______________________________

Printed Name of Circuit Court Judge Signature of Circuit Court Judge

This form must accompany person to the treatment facility.

See s. 394.467(1), Florida Statutes
CF-MH 3008, Feb 05 (obsoletes previous editions) (Recommended Form) **BAKER ACT**

Rights of Persons

In Mental Health Facilities and Programs

The following rights are guaranteed to you under Florida law. These will be fully explained to you at the time of and following admission to this facility. A copy of this form will be given to you to keep. You have the right to read the Baker Act law and rules at any time. Your signature on the form, if you choose to sign, only acknowledges that you have had the rights explained and that a copy of this form was provided to you.

Individual Dignity

You have the right to individual dignity and access to all constitutional rights. The federal Americans with Disabilities Act (ADA) applies to persons in this facility.

Right to Request Discharge by Persons on Voluntary Status

If you request discharge, your doctor will be notified and you will be discharged within 24 hours from a designated community facility and within 3 working days from a state hospital, unless you withdraw your request or you meet the criteria for involuntary placement. If you meet the criteria for involuntary inpatient placement or involuntary outpatient placement, the hospital administrator must file a petition with the Court for your continued stay within two (2) working days of your request for discharge.

Designation of Representative

You will be asked to identify a person to be notified in case of an emergency. Further, if you are at this facility for involuntary examination and do not have a guardian appointed by the court, you will be asked to designate a person of your choice to receive notification of your presence in this facility, unless you request that no notification be made. If you do not or cannot designate a representative, a representative will be selected for you by the facility from a prioritized list of persons. You have the right to be consulted about the person selected by the facility and you can request that such a representative be replaced.

Communication

You have the right to communicate openly and privately by phone, mail, or visitation with persons of your choice during your stay at this facility. You have the right to make free local calls and will be given access to a long distance service for collect calls. If communication is restricted, you will be given a written notice including the reasons for the restrictions. This facility is required to develop reasonable rules governing visitors, visiting hours, and the use of telephones but you cannot be limited in your access to your attorney, to a phone for the purpose of reporting abuse, in contacting Disability Rights Florida, Inc.. Several toll-free telephone numbers you may wish to keep are:

Florida Abuse Registry	1 800 96-ABUSE
Disability Rights Florida, Inc	1 800 342-0823

Confidentiality of Information and Records

Information about your stay in this facility is confidential and may not be released, except under special circumstances, without your consent (or the consent of your guardian or guardian advocate or health care surrogate/proxy if you have one). Special circumstances include release of information to your attorney, in response to a court order, to an aftercare treatment provider, or after a threat of harm to another person. You have the right of reasonable access to your clinical record unless such access is determined to be harmful to you by your physician.

Treatment

You have the right to receive the least restrictive, available, appropriate treatment in this facility. You will get a physical examination within 24 hours of arrival and you will be asked to help develop a treatment plan to meet your individual needs. The criteria, procedures, and required staff training used by this facility for restraints, seclusion, isolation, emergency treatment orders, close levels of supervision, or physical management are available for your review. Such interventions may never be used for punishment, convenience of staff, or to compensate for inadequate staffing.

Advance Directives

You have the right to prepare an advance directive when competent to do so that specifies the mental health care you want or don't want and to designate a health care surrogate to make those decisions for you at the time of crisis. The facility is required to make reasonable efforts to honor those choices or transfer you to another facility that will honor your choices. The facility must document whether you have an advance directive and inform you of its policies about advance directives. There are organizations that can help you prepare an advance directive.

(Continued Over)

Rights of Persons
In Mental Health Facilities and Programs (page 2)

Informed Consent
Before any treatment is given to you, you will be given information about the proposed treatment, the purpose of the treatment, the common side effects of medication you receive, alternative treatments, the approximate length of care, and that any consent given may be revoked at any time by you, your guardian your guardian advocate, or your health care surrogate/proxy. There are additional disclosures that must be made for mediations you receive. If the treatment for which you have given consent is changed at any time during your stay in this facility, it will be fully explained by the staff prior to asking for your written consent to the revised treatment.

Clothing and Personal Effects
You have the right to keep your clothing and personal effects unless they are removed for safety or medical reasons. If they are taken from you, an inventory of the possessions will be prepared and given to you to sign. The possessions will be immediately returned to you or your representative upon your discharge or transfer from this facility.

Habeas Corpus
You or your representative has the right to ask the Court to review the cause and legality of your detention in this facility or if you believe you have been unjustly denied a legal right or privilege or an authorized procedure is being abused. A petition form will be given to you by staff upon your request. If you wish to file a habeas corpus petition, you can submit it to a facility staff member, and it will be filed with the court for you by the facility no later than the next court working day.

Voting
You have the right to register to vote and to cast your vote in any elections unless the court has removed this right from you. Staff will assist you in arranging for registration or voting.

Discharge
You have the right to seek treatment from the professional or agency of your choice after your discharge from this facility.

Person's Signature	Date	Time	am pm
Signature, if applicable, of ☐ Guardian ☐ Guardian Advocate ☐ Representative ☐ Health Care Surrogate/Proxy	Date	Time	am pm
Witness Signature	Date	Time	am pm

This form must be retained in the clinical record as a receipt that the person received notice of his/her rights at the time of admission. A copy must be given to the person and to any authorized decision-maker for persons incompetent or incapacitated by age or disability.

cc: Check when applicable and initial/date/time when copy provided

Individual	Date Copy Provided	Time Copy Provided	Initials of Who Provided Copy
☐ Person		am pm	
☐ Guardian		am pm	
☐ Guardian Advocate		a m pm	
☐ Representative		am pm	
☐ Health Care Surrogate/Proxy		am pm	

See s. 394.459, 394.4615, Florida Statutes
CF-MH 3103, Feb 05 (obsoletes previous editions) (Recommended Form)

BAKER ACT