STATE OF HAWAII
DEPARTMENT OF HEALTH

EMERGENCY EXAMINATION/HOSPITALIZATION: CERTIFICATE OF PHYSICIAN/PSYCHOLOGIST FOR ADMISSION/TRANSPORTATION TO A PSYCHIATRIC FACILITY PURSUANT TO HRS CHAPTER 334-59, AS AMENDED

The undersigned physician/psychologist hereby certifies that he/she is a duly licensed physician or psychologist in the State of Hawaii or is a medical officer of the United States; and that he/she has examined:

(Name of person) (Age) (Sex)

(Number) (Street) (City) (State) (Telephone)

on the _________ day of _________________________, 20_______, at ___________ o'clock, ________M., and

CHECK ALL ITEMS THAT APPLY:

1. That he/she has reasons to believe that the above-named person is:

☐ Mentally Ill
☐ Suffering from Substance Abuse

as manifested by (include examples): ____

2. And, further, that the above-named person is imminently and substantially dangerous to

☐ Self
☐ Other Persons

or is: ☐ Obviously Ill

As manifested by such acts, attempts, or threats as the following: ________________________________

3. And, further that the above-named person is in need of care and/or treatment.

4. Additional circumstances and reasons for this belief, including the reports of others are attached. (Specify):

5. Arrangements have been made to transport the above-named person by:

and deliver him/her to:

Queen's Medical Center and/or Castle Medical Center

________________________________ for emergency examination and/or hospitalization.
(Name of Facility)

I certify under penalty of perjury that the allegations made herein are true of my knowledge except as to matters stated upon information and belief, which I believe to be true

Signed: ____ SIGN HERE ONLY
(Certifying physician or psychologist)

Business address:	Date:/Time:
	Business telephone:
	Home telephone:

TO BE COMPLETED BY PSYCHIATRIC FACILITY

(CHECK AND COMPLETE APPROPRIATE SPACE)

The above-named person was admitted to: ____
(Name of Facility)

for emergency hospitalization on the ____ day of __________________, 20___, at _____ o'clock, __M.,

by the undersigned physician or psychologist,

Signed: ____
(Certifying physician or psychologist)

Name of Facility: ______________________________
Address: ______________________________
____

Date: _________________________

The above-named person was transferred to: ____
(Name of Facility)

for emergency hospitalization on the _____ day of ____________________, 20___, at _____ o'clock, __M.,

by the undersigned physician or psychologist,

Name of Facility: ______________________________
Address: ______________________________
____

Date: _________________________

TO BE COMPLETED BY THE PSYCHIATRIC FACILITY

The above-named person who was transferred to: ____
(Name of Facility)

for emergency hospitalization from ____
(Name of Facility)

on the ______ day of ____________________________________, 20___, at _____ o'clock, __M., was again

transferred to ____ for
(Name of Facility)

further emergency hospitalization on the ____ day of _________________, 20___, at _____ o'clock, __M.,

by the undersigned physician or psychologist.

Signed: ____
(Certifying physician or psychologist)

Name of Facility: ________________________________
Address: ________________________________
____

Date: __________________________