NO. _________________

THE STATE OF TEXAS	§	IN THE ______ COURT OF
FOR THE BEST INTEREST	§	
AND PROTECTION OF	§	
	§	
_____ (Initials Only)	§	
THE PROPOSED PATIENT	§	_______ COUNTY, TEXAS

PHYSICIAN'S CERTIFICATE OF MEDICAL EXAMINATION
FOR MENTAL ILLNESS FOR **OUTPATIENT** COMMITMENT

I, the undersigned, a person licensed to practice medicine in the State of Texas, or a person employed by an agency of the United States having a license to practice medicine in any state of the United States, do hereby certify, to wit:

1. That my name (***physician***) and ***address***, ***telephone number, and cell phone*** are:
   ____
   ____

2. That on the _______ day of ______________________, 202___, at the following location:
   ____, I evaluated and examined
   ______________________________, hereafter called ***"Patient"***.

3 Prior to this examination, the Patient

   ( ) was
   ( ) was not

   informed that communications with me would not be privileged.

4. The Patient has been under my care for the following, if any, period of time:
   ____

5. A brief diagnosis of the physical and mental condition of the Patient on said date is:
   ____
   ____

6. An accurate description of the mental health treatment, if any, given by me or administered under my direction is as follows:
   ____
   ____

7. I am of the opinion that the Patient is mentally ill and that the nature of the mental illness is severe and persistent; and

   that as a result of the mental illness, the proposed patient will, if not treated, experience deterioration of the ability to function independently to the extent that the proposed patient will be unable to live safely in the community without court-ordered outpatient mental health services;

   and outpatient mental health services are needed to prevent a relapse that would likely result in serious harm to the proposed patient or others;

and that the proposed patient has an inability to participate in outpatient treatment services effectively and voluntarily, demonstrated by: (i) any of the proposed patient's actions within the immediately preceding two-year period; or (ii) specific characteristics of the proposed patient's clinical condition that make impossible a rational and informed decision about whether to submit to voluntary outpatient treatment.

8. The following information confirms the deterioration of the Patient's ability to function independently to the extent that the Patient will be unable to live safely in the community; the need for outpatient mental health services to prevent a relapse that would likely result in serious harm to the Patient or others; and the Patient's inability to participate in outpatient treatment services effectively and voluntarily:

____
____
____
____
____
____.

9. (NOTE: COMPLETE THIS ITEM ***ONLY*** IF THIS CERTIFICATE IS TO BE OFFERED IN SUPPORT OF COURT-ORDERED EXTENDED OUTPATIENT MENTAL HEALTH SERVICES.)

( ) the Patient's condition is expected to continue for **more than 90 days**,
( ) the Patient has received:
(i) court-ordered inpatient mental health services under this subtitle or under Subchapter D or E, Chapter 46B, Code of Criminal Procedure, for a total of at least 60 days during the preceding 12 months; or
(ii) court-ordered outpatient mental health services under this subtitle or under Subchapter D or E, Chapter 46B, Code of Criminal Procedure, during the preceding 60 days.

"My name is ____; my date of birth is ___/_____/______;

and my address is ____.
(Street) (City) (State) (Zip code)
I declare under penalty of perjury that the foregoing is true and correct.

Executed in _____ County, State of TX, on the ___ day of ____________, 202___."

____
SIGNATURE OF EXAMINING PHYSICIAN