| | IN THE CIRCUIT/COUNTY | COURT OF THE | JUDICIAL CIRCUIT | |
|-----------------------|--|---------------------------|--|--------------------|
| | IN AND FOR | | COUNTY, FLORIDA | |
| IN RE: | | | | |
| | | | | |
| | Petition for Ir | nvoluntary Inpatie | ent Placement | |
| COMES NOW the | Petitioner, | | | , and alleges: |
| 1. That Petitioner i | s Administrator of Name of Fac | | | |
| | Name of Fac | cility F | Facility Address | |
| 2. That (Name of I | ndividual) | | | , is a |
| patient of said fa | acility and has been examined at | such facility. | | |
| | digits of the individual's social s | security number are | and date of birth | |
| is: | · | | Date | |
| 4. That this petition | n is being filed within the follow | ing time frames: (Check | one below) | |
| | | | s petition is being filed within the and or legal holiday, on the next cou | |
| | ividual was transferred to involu sting discharge from the facility a | | nation or after refusing/revoking conwithin two court working days. | nsent to treatment |
| | ereto and by reference made a par voluntary inpatient placement. | rt hereof, are two (2) op | inions regarding the mental health o | of said individual |
| 6. That based there | on Petitioner recommends that the | he individual/responden | t be involuntarily placed in | |
| | | , a (public/pi | rivate) designated receiving or treat | ment facility. |
| 7. In addition to at | least one of the two experts who | | l, the following persons may testify | |
| | Witness | Witness | Witness | |
| Name: | | | | |
| Relationship | o | | | |
| Address | | | | |
| | | | | |
| Telephone: | () | () | () | |
| reteptione. | \ | · | | |

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Petition for Involuntary Placement (Page 2)

| COMES NOW THE PET | ITIONER and further alleges | that: | | | | |
|---------------------------|--|-----------------------|-----------------------|-----------------|-----------|--------|
| mental health or m | eate is necessary to act on the anedical treatment and a Petitio Guardian Advocate is attached | n for Adjudication of | | | | ent to |
| | pondent is competent to provi pardian authorized to consent | | | | ent or th | e |
| Signature of Facility Adm | ninistrator or Designee | Date | | Time | am | pm |
| Typed or Printed Name of | of Administrator or Designee | | | | | |
| The individual | s or | a private attorney. | If so, the name and a | ddress of the p | orivate | |
| 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 |
|------------------------------|--------------------|--------------------|----------------------------------|
| ☐ Individual | | am pm | |
| ☐ Guardian | | am pm | |
| ☐ Public Defender | | am pm | |
| ☐ Representative | | am pm | |
| State Attorney | | am pm | |
| Dept. of Children & Families | | am pm | |

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Petition for Involuntary Placement (Page 3)

| First Opinion Supporting the Petition | | | | | | |
|---|--|--|--|--|--|--|
| 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: | | | | | | |
| Said individual has a mental illness and because of a mental illness (check one): a. Said individual has refused voluntary placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of placement for treatment; OR b. Said individual is unable to determine for himself/herself whether placement is necessary: AND Either (Check one or both): | | | | | | |
| a. Said individual is 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 individual 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 individual'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, | | | | | | |
| Name of Individual find that he/she meets the criteria for involuntary inpatient placement as stated | Date , (within 72 hours of signing hereof), and Date | | | | | |
| find that he/she meets the effecta for involuntary inpatient placement as stated | in this petition. Observations which support this opinion are. | | | | | |
| Signature of Examiner | Date Time am pm | | | | | |
| Typed or Printed Name of Examiner | Profession License Number | | | | | |
| I certify that no psychiatrist or clinical psychologist is available to provide the second opinion. | | | | | | |
| Printed Name and Signature of Administrator or Designee | Date | | | | | |

* If the facility administrator certifies that a psychiatrist or clinical psychologist is not available to provide the second opinion, it may be provided by a licensed physician who has postgraduate training and experience in diagnosis and treatment of mental illness or by a psychiatric nurse.

BAKER ACT