FORM 12-10

Notice of Certification for Second Involuntary 14-Day Period for Intensive Treatment — Suicidal Patient

To the Superior Court of the State of California for the County of _____.

The authorized agency providing 14-day intensive treatment, County of _____, has custody of:

Name: _____

Address: _____

Date of birth: _____ Sex: _____Marital Status: _____

Religious Affiliation: _____

The undersigned allege that the above-named person presents an imminent threat of taking his/her own life. This allegation is based upon the following facts: _____

_____

_____

This allegation is supported by the accompanying affidavits signed by: _____

_____

The above-named person has been informed of this allegation and has been advised of, but has not been able or willing to accept referral to, the following services: _____

_____

_____

Therefore we certify the above-named person to receive additional intensive treatment for no more than 14 days beginning this _____day of *(month)* _____, 20_____, in the intensive treatment facility herein named: _____.

We hereby state that a copy of this notice has been delivered this day to the above-named person and that he/she has been clearly advised of his/her continuing legal right to a judicial review by habeas corpus, that the term "habeas corpus" has been explained to him/her, and his/her right to counsel, including court-appointed counsel pursuant to Welfare and Institutions Code Section 5276.

Date: _____ Time: _____ AM / PM

Signature: _____
(physician/staff member of facility)

Date: _____ Time: _____ AM / PM

Countersignature: _____
(representing intensive treatment facility)

(over)

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COPIES:

Patient: _____

Patient's attorney or representative: _____

Other person designated by patient: _____

Superior Court (to be submitted with the psychiatric certification review hearing decision)

District Attorney

Facility Providing Intensive Treatment

Reference: Welfare and Institutions Code Sections 5262, 5263 and 5276

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FORM 12-10S

Aviso de Remision a un Segundo Periodo Involuntario de 14-Dias para Tratamiento Intensivo — Paciente Suicida

Al Tribunal Superior del Estado de California para el Condado de _____.

La dependencia autorizada que proporciona tratamiento intensivo de 14 días, Condado de _____ _____ tiene la custodia de:

Nombre: _____

Dirección: _____

Fecha del nacimiento: _____ Sexo: _____ Estado Civil: _____

Afiliación religiosa: _____

Los suscritos afirman que la persona arriba nombrada presenta la amenaza inminente de suicidarse. La presente afirmación se basa en los siguientes hechos: _____

_____

_____

Se apoya a la presente afirmación con las declaraciones juradas firmadas por: _____

_____

Se le ha notificado a la persona arriba nombrada de dicha afirmación, y se le ha informado de los siguientes servicios, pero no ha querido o no ha sido capaz de aceptar ser referido a los mismos:

_____

En tal virtud, remitimos a la persona antes mencionada para recibir tratamiento intensivo adicional por un plazo no mayor de 14 días a partir de este día _____ de *(mes)* _____ _____de 20_____, en la institución e tratamiento intensivo nombrada a continuación: _____.

We hereby state that a copy of this notice has been delivered this day to the above-named person and that he/she has been clearly advised of his/her continuing legal right to a judicial review by habeas corpus, that the term “habeas corpus” has been explained to him/her, and his/her right to counsel, including court-appointed counsel pursuant to Welfare and Institutions Code Section 5276.

Date: _____ Time: _____ AM / PM

Signature: _____
(physician/staff member of facility)

Date: _____ Time: _____ AM / PM

Countersignature: _____
(representing intensive treatment facility)

(sobre)

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Patient: _____

Patient's attorney or representative: _____

Other person designated by patient: _____

Superior Court (to be submitted with the psychiatric certification review hearing decision)

District Attorney

Facility Providing Intensive Treatment

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