

SIGNATURES FOR CONDITIONAL DISCHARGE

The information set forth in the attached forms:

- 609-2 RECOMMENDATION for CONDITONAL DISCHARGE (CD);
- 609-3 TERM AND CONDITIONS OF DISCHARGE (CD); and
- 609-4 NOTICE OF CONDITIONAL DISCHARGE (CD) PROVISIONS AND REVOCATION PROCEDURES,

has been presented to me orally and in writing by hospital staff.

I AGREE to abide by the TERM and CONDITIONS of DISCHARGE (CD) as set forth in Form 609-3.

I UNDERSTAND the CONDITIONAL DISCHARGE (CD) PROVISIONS AND REVOCATION PROCEDURES as set forth in Forms 609-3 & 4 (two pages).

Signature of Patient Date

Signature of Guardian over Person (if any) Date

 As the representative for the **Designated Receiving Facility**, I agree that I have presented Forms 609-2, 609-3, and 609-4, both orally and in writing, to the patient named above.

Signature of DRF Representative Date

 As the representative of the **Mental Health Center**, I agree to the **TERM and CONDITIONS** of the patient's/client's conditional discharge (CD). I understand and acknowledge that the **Mental Health Center** is responsible for providing a prescribed regimen of care and treatment to the patient/client to help prevent the recurrence of the circumstances which led to his/her dangerous condition and to **ENFORCE** the **TERM and CONDITIONS** of the patient's/client's conditional discharge (CD).

Signature of Community Mental Health Center Representative Date

 I hereby grant a **CONDITIONAL DISCHARGE (CD)** to:

Patient Name

in accordance with RSA 135-C:49 and He-M 609 subject to the **TERM and CONDITIONS** (CD) set forth on the attached Form 609-3.

Signature of Facility Administrator Date

RECOMMENDATION FOR
CONDITIONAL DISCHARGE (CD)

I have determined that pursuant to He-M 609.02(k):

Patient's Name

Street Address

City

State

Zip

Phone Numbers

requires a prescribed regimen of care and treatment to prevent the recurrence of the circumstances which led to his/her dangerous condition and admission to:

Cypress Center

Elliott Hospital

Franklin Regional Hospital

New Hampshire Hospital

I therefore recommend that s/he be granted a **CONDITIONAL DISCHARGE (CD)** subject to the term and conditions set forth on the attached Form 609-3.

Signature of Psychiatrist

Date

TERM OF CONDITIONAL DISCHARGE (CD)

Printed Name of Patient/Client Date

- 1. **Circuit Court, Probate Division,** _____ : _____
(Location of court) (Date of decision)
- 2. **Conditional Discharge (CD) Date:** _____
(Date CD begins and Patient Discharged)
- 3. **Absolute Discharge Date:** _____
(Date court order expires)
- 4. **COMMUNITY MENTAL HEALTH CENTER:** _____
(Name of Community Mental Health Center)

CONDITIONS OF CONDITIONAL DISCHARGE (CD)

I, _____, agree not to engage
Printed Name of Patient/Client
in behaviors that may cause me to be a danger to myself and/or
to others and to abide by the following conditions:

- 1. To take all medications as prescribed by the mental health center psychiatrist/APRN.
- 2. To attend ALL scheduled appointments, in which I have received at least 24 hours verbal notice, with the mental health center treatment team members, including, but not limited to my psychiatrist, APRN, case manager, and functional support assistant.
- 3. To participate in all lab screenings, as prescribed by the mental health center psychiatrist and/or APRN, immediately upon verbal, or in writing, request.
- 4. To refrain from the use of alcohol or other non-prescription medications/illicit drugs, to the extent it adversely affects my ability to participate in treatment.
- 5. _____
(Use this space to add a separate condition as needed.)
- 6. _____
(Use this space to add a separate condition as needed and/or attach a separate page.)

Signature of Patient/Client Date

Signature of Guardian over Person (if any) Date

CONDITIONAL DISCHARGE (CD) PROVISIONS
AND REVOCATION PROCEDURES-NOTICE

Printed Name of Patient/Client _____

Date: _____

1. **REVOCATION/EXTENTION/CONTINUATION**: Your CD may be revoked, extended, or continued pursuant to RSA 135-C.
2. **TRAVEL**: Before making plans to travel outside the State of New Hampshire for any reason, you need to consult with your mental health treatment provider at the mental health center.
3. **CHANGING COMMUNITY MENTAL HEALTH CENTERS**: Before making plans to move to a different region with a different mental health center, you MUST consult with your treatment team at (circle one):

1-Northern Human Services	2-West Central Behavioral Health	3- Genesis Behavioral Health
4-Riverbend Mental Health	5-Monadnock Family Services	6-Greater Nashua Mental Health
7-Mental Health Center of Greater Manchester	8-Seacoast Mental Health Center	9-Community Partners
		10-Center for Life Management

4. **REVISING THE CONDITIONAL DISCHARGE**: He-M 609.05(a)(4) provides that your conditional discharge (CD) **may** be revised, (which includes changing to a different mental health center) so long as you:
 - a. **Participate** in a client-centered conference to discuss the proposed revisions; and
 - b. **Agree**, in writing, with your community mental health center psychiatrist or APRN to the proposed revisions/changes.
5. **MENTAL HEALTH EXAMINATION**: The community mental health center psychiatrist or APRN shall conduct a mental health examination of you, or designate a member of the treatment team or an emergency services staff member to conduct a mental health examination of you, to determine whether to revoke your conditional discharge (CD) if s/he has reason to believe that you:
 - a. **Violated** one or more of the conditions of your discharge (CD); and/or
 - b. Are in such condition as to create a **potentially serious likelihood of danger** to yourself or others.
6. **PROPOSED (Form 609-7 WRITTEN NOTICE): BEFORE** your mental health examination, the community mental health center psychiatrist, APRN, or designee shall:
 - **Offer** you a copy of the **PROPOSED** revocation & **explain** it; and
 - **Advise** you that you have the right to a hearing if you are returned to the hospital.

Patient's Initials _____ Guardian's Initials _____ Date: _____

7. COMPEL EXAMINATION (Form 609-7):

If you:

- Refuse to meet with staff from the mental health center; OR
- Refuse to undergo a mental health examination, OR
- Cannot be located by staff from the mental health center after s/he uses reasonable efforts to find you,

the psychiatrist or APRN, shall issue an order to **COMPEL** you to participate in a mental health examination by asking a law enforcement officer to locate you and transport you to the nearest hospital emergency room or an office at the mental health center where the mental health examination will occur.

8. TEMPORARY (WRITTEN NOTICE Form 609-7):

Before **TEMPORARILY** revoking your conditional discharge (CD), the mental health center psychiatrist/APRN or designee must:

- **Offer** a copy of the **PROPOSED** revocation and **explain** it to you;
- **Perform** a mental health **EXAMINATION** to assess your functioning;
- **Offer** a copy of the **TEMPORARY** revocation and **explain** it to you; and
- **Advise** you that you have a right to have a **hearing** if you object.

9. **TRANSPORTATION:** If your conditional discharge (CD) is **TEMPORARILY** revoked, a law enforcement officer shall transport you to a designated receiving facility. (NHH, Elliot Hospital, Cypress Center, or other DRF.)

10. **ABSOLUTE (WRITTEN NOTICE FORM 609-10):** Within 3 days of your arrival at the a designated receiving facility, your treating psychiatrist shall:

- **Perform** a mental health **EXAMINATION** of you; **AND**
- **OVERTURN** the **TEMPORARY** revocation of your CD; **OR**
- **OFFER** you a copy of the **ABSOLUTE** revocation and **explain** it;
- **Advise** you that you have the right to have a **hearing**.

11. **Significant Risk of Bodily Harm:** If a MHC staff member or hospital staff member cannot safely **EXPLAIN** the written revocation forms to you (**Proposed, Temporary, and Absolute**) without significant possibility of bodily harm, due to your behaviors, the staff member may refrain from **explaining** the reasons for revocation to you and continue to revoke your conditional discharge (CD), so long as s/he describes the circumstances indicating such risk and places it in the file.

12. **APPEAL:** You have the right to **APPEAL** the **ABSOLUTE** revocation of your conditional discharge (CD) and to be represented by an attorney. Your attending psychiatrist/APRN and/or social worker shall provide you with Forms 609-9 and 609-10 for your appeal.

Patient's Initials _____ Guardian's Initials _____ Date: _____