FORM 609-1 _____

Patient/Client Name

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

Form Effective Date: 07/01/2015

FORM 609-2

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/APRN Date

FORM 609-3

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):

◯ Northern Human Services	◯ West Central Behavioral Health	◯ Genesis Behavioral Health
◯ Riverbend Mental Health	◯ Monadnock Family Services	◯ Greater Nashua Mental Health
◯ Mental Health Center of Greater Manchester	◯ Seacoast Mental Health Center	◯ Community Partners
		◯ 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: _____

Patient/Client Name

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, Franklin Regional Hospital 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: _____

FORM 609-5

_____
Patient/Client Name

TRANSFER/REVISIONS

We, _____ and
Name of Community Mental Health Center Psychiatrist/APRN

_____, convened a
Name of Client

client-centered conference on _____(date) at:

Name and Address of Community Mental Health Center

We agreed, after engaging in a client-centered conference, as follows:

☐ Authority to monitor and enforce the conditional discharge (CD) for the client named above has been **TRANSFERRED** to:

(Name of Community Mental Health Center and Name of Representative or Case Manager)

☐ The client and receiving MHC shall execute a new CD within 2 weeks of the intake appointment AND the current CD is valid until a new CD is adopted and executed by the receiving MHC.

☐ The CD dated _____is **REVISED** by including the following additional condition(s): _____

_____

****

_____ _____
Signature of Client Date

_____ _____
Signature of Guardian over Person (if any) Date

_____ _____
Signature of Sending Mental Health Center Designee Date

_____ _____
Signature of Receiving Mental Health Center Designee Date

THESE CHANGES ARE INCORPORATED INTO THE CONDITIONAL DISCHARGE (CD) AND SHALL BE INCLUDED IN THE RECORD AT ALL TIMES FOR REFERENCE.

☐ A COPY OF THIS DOCUMENT WAS SENT TO NHH LEGAL SERVICES ON _____ (Initials of person from receiving MHC_____)