

**OFFICERS MENTAL HEALTH CONTACT REPORT
VOLUNTARY/INVOLUNTARY COMMITS**

Client Name	D.O.B.	Date
Address	Phone	S.S. Number

SUMMARY OF LOCATION AND REASON FOR CONTACT: _____

CASE NUMBER: _____

WITNESS/OTHER CONTACT (NAME, RELATIONSHIP, PHONE)

CHECK APPROPRIATE SELECTION:

- | | |
|--|--|
| <input type="checkbox"/> WEAPONS | <input type="checkbox"/> MEDICAL PROBLEMS |
| <input type="checkbox"/> PRIOR RELATED CONTACTS | <input type="checkbox"/> DRUG INVOLVEMENT |
| <input type="checkbox"/> SUICIDAL | <input type="checkbox"/> ALCOHOL INVOLVEMENT |
| <input type="checkbox"/> HOMICIDAL/THREATS TO OTHERS | <input type="checkbox"/> AGREES TO MENTAL HEALTH TREATMENT |
| <input type="checkbox"/> UNABLE TO CARE FOR SELF | <input type="checkbox"/> REFUSES MENTAL HEALTH TREATMENT |
| <input type="checkbox"/> DANGER TO PROPERTY | |

OFFICER (PRINT)	ID#	DUTY PHONE	DEPARTMENT
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