

Georgia Department of Behavioral Health and
Developmental Disabilities (DBHDD)

**FORM 1014 CERTIFICATE AUTHORIZING
TRANSFER FROM EMERGENCY RECEIVING
FACILITY TO EVALUATING FACILITY**

Identification _____

This is to certify that I have examined _____, who was admitted to _____, an emergency receiving facility as defined by Georgia Law, on _____ at _____ (a.m./p.m.). The time of admission to the emergency receiving facility was within forty-eight (48) hours preceding the time of the signing of this certificate. I examined the individual on _____ at _____ (a. m. /p. m.) Based on this examination, it is my conclusion that there is reason to believe that the above-named individual may be a mentally ill person requiring involuntary treatment in that he/she may be mentally ill **AND (a)** may present a substantial risk of imminent harm to himself/herself or others as manifested by either recent overt acts or recent expressed threats of violence which present a probability of physical injury to himself/herself or to other persons, or **(b)** may be so unable to care for his/her own physical health and safety as create an imminently life-endangering crisis. Based on this conclusion, the above named individual should be evaluated in an evaluating facility for possible admission to a treatment facility.

_____ PRINTED NAME

_____ SIGNATURE

DATE _____, 20____ at _____ am/pm

NOTE: The signing of this form allows the evaluating facility to admit the individual involuntarily for evaluation for up to five (5) days, not counting Saturdays, Sundays and holidays.

For Staff Use Only – A copy of Form 1014 is placed in the clinical record.

Signature of Staff

Title

Date