PATIENT TRANSFER (UNDER C.G.S. Section 17a-511)
BETWEEN HOSPITALS FOR PSYCHIATRIC DISABILITIES
M-24 Rev. 3/99

TO: COMMISSIONER OF MENTAL HEALTH AND ADDICTION SERVICES
STATE OF CONNECTICUT

<table>
<tr><td rowspan="2">TRANSFER</td><td colspan="3">From (Sending Institution)</td><td>Date Admitted</td></tr>
<tr><td colspan="3">To (Receiving Institution)</td><td>Date Admitted</td></tr>
<tr><td>PATIENT</td><td colspan="2">Full Name (Last, First, Initial)</td><td>Religion</td><td>Date of Birth</td></tr>
<tr><td rowspan="2">INTERESTED PARTIES</td><td colspan="3">Name and Address of Correspondent (if applicable)</td><td>Tel. No.</td></tr>
<tr><td colspan="3">Name and Address of Next of Kin (if applicable)</td><td>Tel. No.</td></tr>
<tr><td rowspan="4">PHYSICIAN’S STATEMENT</td><td colspan="4">Legal Status of Patient (cite statute)</td></tr>
<tr><td colspan="4">Current Medication</td></tr>
<tr><td colspan="4">Clinical Reasons for Transfer</td></tr>
<tr><td>Date</td><td>Physician’s Name</td><td colspan="2">Physician’s Signature</td></tr>
<tr><td>CAUTIONS</td><td colspan="4">(Suicidal, Assaultive, etc.)</td></tr>
<tr><td>COURT REPORTS</td><td colspan="4">Due (Date or Time Period)</td></tr>
<tr><td>KEY COMMUNITY RELATIONSHIPS</td><td colspan="4"></td></tr>
<tr><td>SPECIAL CONDITIONS</td><td colspan="4"></td></tr>
</table>

Other Remarks, if any

<table>
<tr><td rowspan="3">INSTITUTION</td><td colspan="4">We, the undersigned, agree to the transfer, as described above, of the patient named above. Such transfer is hereby authorized with the approval, of the Commissioner of Mental Health and Addiction Services, or in the case of a person under eighteen years of age, the approval of the Commissioner of Children and Families, as embodied in the General Statutes of the State of Connecticut, under the Section stated above.</td></tr>
<tr><td>Sending Institution</td><td>Date</td><td>Superintendent’s Name</td><td>Superintendent’s Signature</td></tr>
<tr><td>Receiving Institution</td><td>Date</td><td>Superintendent’s Name</td><td>Superintendent’s Signature</td></tr>
</table>

Distribution: Original form is sent with the patient to the Receiving Institution
Copy of form is filed in the patient’s medical record

Involuntary Patients: Copy of the transfer form is *filed with the court* by which such person was committed.

Voluntary Patients: Copy of the transfer form is *given to the patient*.

A copy of the fully executed transfer form, including the signature of the receiving facility's CEO, is obtained and filed in the patient's medical record.

Addendum to Form M-24 for Involuntary Transfer of Involuntary Inpatient to Whiting Maximum Security Service

Patient Name: DOB:

Sender:

Sender's statement of facts

(to be completed by Sender's Medical Director or physician designee)

What current/recent violent or aggressive behavior(s) creates a risk of imminent physical harm to self/others in the current treatment environment?

What efforts have been made in the current treatment environment to manage this risk **and why have they not been successful** in sufficiently ameliorating such risk?

Has a consultation occurred with the Medical Director of the Whiting Forensic Hospital (or other physician designee)?

Date / time of consultation:

Parties involved in consultation:

What less restrictive interventions have been considered and why are they not adequate to manage the risk?

Is further evaluation of risk management recommended?

Are alternative treatment interventions recommended to manage this risk?

Do the medical directors (or designees) agree that transfer to WMS is the necessary intervention to manage the present risk of imminent physical harm to self/others?

How are the supervision, structure and security of WMS expected to achieve amelioration of risk?

Sender's Medical Director Print Name _____

I attest that I have completed this form myself or, if completed by others, have reviewed it and affirm the contents in their entirety. I also acknowledge that this form will 1) become part of the patient' medical record; 2) be copied and given to the patient; and 3) be copied and given to the patient's attorney or other advocate identified by the patient. I understand that the admission of a civil patient to a maximum security forensic hospital is a serious matter, with important implications for the patient, and that it should only be sought in the most difficult situations of uncontrollable aggressive behavior.

Signature _____ Date _____

Copies: ***(Check as Applicable)***

1 to probate court of record (always required) __✓_

1 to patient's medical record at sender (always required) __✓_

1 to patient's medical record at WMS (always required) __✓_

1 to patient (always required) __✓_

1 to any legal advocate or other person designated by the patient (with patient's informed consent and signed Release of Information) _____

Notice to Patient

You have the right to an advocate to help you if you object to this transfer.

You and/or your advocate have the right to apply to the probate court to modify or revoke this transfer under state law: CGS 17a-511(a)

WFH CEO Periodic Review of Patient Transferred to Whiting Maximum Security Service

Patient Name: DOB:

Hospital/Facility from which patient was transferred to WMS:
Date of transfer:

Date of report:

(check one):
Transfer of involuntary civil patient under 17a-511(a) ____ (report every 2 weeks)

Voluntary transfer of voluntary civil patient from other hospital/facility under 17a-511(b)____ (report every 3 months)

The patient no longer requires continued treatment in the maximum security setting ____

The patient continues to require treatment in the maximum security setting ____
(*describe reasons here*)

WFH CEO or Designee

Print Name _____ Signature _____ Date _____

DMHAS Commissioner's Designee Approval of Continued Treatment in WMS

I approve the continued treatment of the patient at WMS, based on the documentation provided.

WMS is no longer the least restrictive alternative for the patient's treatment. _____

Print Name _____ Signature _____ Date _____

Copies: 1 to patient's medical record at WMS (always required) __✓__
(Check as Applicable) 1 to patient (always required) __✓__
1 to any legal advocate or other person designated by the patient (with patient's informed consent and signed Release of Information) _____

Addendum to Form M-24 for Voluntary Transfer of Voluntary Inpatient to Whiting Maximum Security Service from outside Whiting Forensic Hospital

Patient Name: DOB:
Sender:

Sender's statement of facts
(to be completed by Sender's Medical Director or physician designee)

What is the patient's understanding of the nature of the WMS treatment setting and how it differs from the patient's current treatment setting?

Is the patient's consent voluntary (explain)?

What is the clinical and/or security rationale for accepting the patient's request for transfer to WMS?

Sender's Medical Director Print Name: _____

Signature: _____ Date: _____

Copies: ***(Check as Applicable)***

1 to patient's medical record at sender (always required) __✓__

1 to patient's medical record at WMS (always required) __✓__

1 to patient (always required) __✓__

1 to any legal advocate or other person designated by the patient (with patient's informed consent and signed Release of Information) _____

Notice to Patient

You have the right to an advocate to help you with this transfer.

You still have the right to request discharge from the hospital (as a voluntary patient