



**CERTIFICATION REVIEW HEARING
ORDER**

Case No. _____
Court _____
County _____
Division _____

IN THE INTEREST OF: _____
Respondent

A Certification Review Hearing was held on _____; (*check one*) ☐ the Qualified Mental Health Professional (QMHP) testified about the certification ☐ the Court accepted the certification in lieu of testimony upon agreement of all parties and stipulation by Respondent that he/she meets the criteria for involuntary hospitalization under KRS 202A.026 provided that outpatient treatment is determined to be the least restrictive mode of treatment; and any other evidence presented having been considered;

The Court HEREBY FINDS (*check one*) ☐ there is ☐ there is NOT clear and convincing evidence that Respondent (1) is an individual with a mental illness, (2) who presents a danger or threat of danger to self, family, or others as a result of the mental illness, (3) who may reasonably benefit from court-ordered outpatient treatment or release with other reasonable conditions, and (4) for whom court-ordered outpatient treatment or release with other reasonable conditions is the least restrictive alternative mode of treatment available;

THEREFORE, the Petition for Involuntary Hospitalization is DENIED, and IT IS HEREBY ORDERED: (*check one*) ☐ Respondent shall receive community-based outpatient treatment that shall not exceed 360 days. A treatment plan in accordance with KRS 202A.0801 shall be developed by _____ (agency/QMHP) within 48 hours. Respondent shall also comply with the following conditions necessary to ensure compliance: _____

_____. (Doc. Code: OCCOT)

OR
☐ Respondent shall be released with the following conditions necessary to ensure the safety of self, family, or others and avoid readmittance to a hospital setting: _____

_____. (Doc. Code: OCRC)

OR
☐ These proceedings are DISMISSED and Respondent shall be released with no further conditions. (Doc. Code: OCDIS)
(*check if applicable*) ☐ The preliminary hearing scheduled in this matter is cancelled.

Date

Judge's Signature

Please print or type name of Judge in the space provided below:

Distribution: Petitioner
Hospital / Facility

Respondent
Outpatient Provider

Respondent's Attorney
BHDID (if outpatient treatment ordered)

County Attorney

Print Form

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