JO ANNE BERNAL
EL PASO COUNTY ATTORNEY
EL PASO COUNTY COURTHOUSE
500 E. SAN ANTONIO, ROOM 503
EL PASO, TX 79901

Phone (915) 546-2084
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APPLICATION FOR EMERGENCY DETENTION

Please submit the application to:

El Paso County Attorney's Office

Mental Health Unit

500 E. San Antonio, Room 503

El Paso, Texas 79901

Phone: 915-546-2084

Fax: 915-543-3818

Michele Rodriguez michele.rodriguez@epcounty.com

Marisol Nevarez Manevarez@epcounty.com

DEADLINE TO SUBMIT APPLICATION IS 1:00 PM

Office Hours 8:00AM – 5:00PM

Monday –Friday

Jail Magistrate- County
(ONLY by Physician)
FAX: (915) 546-2256
Phone: (915) 546-2077

APPLICATION FOR EMERGENCY DETENTION
BY ANY ADULT

Date of Application _____ **Time**:_____ ___

1. INFORMATION ON THE PERSON FOR WHOM YOU ARE SEEKING THE EMERGENCY DETENTION:

Name: _____DOB: _____AGE:_____

Home Address:_____ City: _____ Zip Code: _____

Home Phone#: _____ Cell#: _____ Other Contact#: _____

How long has the person been at their present address? _____

If the person CANNOT be found at his/her home address, please provide an address where the person CAN be found: _____

Have you contacted law enforcement prior to submitting the Application for Emergency Detention? YES NO

If YES, when was the last time? _____

What was the outcome? _____

2. APPLICANT INFORMATION:

Applicant's Name: _____

Home Address:_____ City: _____ Zip Code: _____

Home Phone#: _____ Cell#: _____ OTHER#: _____

Place of Employment: _____

Work Address: _____ Work Phone#: _____

Email address_____

What is your relationship to the person for whom you are seeking an emergency detention?

_____

When and where did you last see or hear from proposed patient? _____

_____

3. EVIDENCE OF MENTAL ILLNESS:

Does the person have a mental illness **diagnosis?** **YES** **NO**

If "**YES**", what is the diagnosis? (e.g., *Bipolar disorder, schizophrenia)*:

_____

When was the person diagnosed? _____

Has this person been prescribed medication? **YES** **NO**

When was this person prescribed the medication?

_____

Has this person been taking their medication as directed? **YES** **NO**

How long has the patient been taking or not taking their prescribed medications?

_____

Which medications were prescribed to this patient? _____

_____.

Who prescribed the Medications? _____.

When did the patient last see the doctor? _____.

4. RISK OF HARM TO SELF: YES NO

Please provide a **detailed** account of how this person has physically harmed, attempted to physically harm or threaten to harm him/herself **within the past 10 days.** ***Please include the date (s) when incident (s) occurred***:_____

_____

_____

_____

5. RISK OF HARM TO OTHERS: YES NO

Please provide a **detailed** account of how this person has **physically** harmed, attempted to **physically** harm or threatened to harm another person **within the past 10 days.** In addition, include the name of the person who received any injuries, **and when** it occurred:

_____

_____

_____

_____

6. BEHAVIOR:

To your knowledge, does this person eat, sleep and drink regularly? If not, please describe their eating and drinking habit and the length of time for this behavior. _____

Please describe the person's living conditions and indicate how long it has been this way _____

_____

_____

_____

Does this person have good hygiene, if not please give a detailed description of the person's condition and how long it has been this way.

_____

_____

_____

_____

7. Guardianship Information

Is this person under a guardianship? **YES** **NO**

If yes, when was the guardianship granted and under what circumstances? _____

_____

_____

_____

Please provide contact information for guardian:

Name_____ Case number _____

Address_____ Phone _____

8. WITNESS INFORMATION:

Please list the names, addresses and phone numbers of any witnesses to the incidents you have described above.

NAME **ADDRESS** **PHONE**

_____

_____

_____

COMMENTS BY APPLICANT

_____

_____

_____

_____

_____

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_____

_____

INITIAL THE FOLLOWING:

_____ I do certify that statements made in this application are true and correct.

_____ I have reason to believe the person named in this application poses an imminent risk of harm to themselves or others unless the person is immediately restrained.

_____ I have reason to believe that this person has a mental illness.

_____ I understand that there are consequences under the Texas Penal Code and the Texas Mental Health Code for falsifying any information or bringing this suit for any reason other than to obtain a mental health evaluation for this person.

_____ I further understand that I may be called to testify in court to the statements made in this application.

_____ _____

DATE **SIGNATURE**

_____

PRINTED NAME

FILED THIS _____ day of _____, 20_____ at _____ a.m. / p.m. with the office of the COUNTY CLERK.

_____

Deputy

Delia Briones, County Clerk

ADDITIONAL COMMENTS BY APPLICANT