Date

Hospital Name

Hospital Address

City, State, Zip

Court Department \_\_\_\_\_\_\_\_ *(Please indicate the name of the court - District, Boston Municipal, or Juvenile Court)*:

Re: Hospital/Physician Affidavit Letter Supporting Section 35 Petition

My name is \_\_\_\_\_\_\_\_\_\_\_, and I am a licensed physician in the Commonwealth of Massachusetts and Board Certified in \_\_\_\_\_\_\_\_\_.

I most recently evaluated \_\_\_\_\_\_\_\_\_\_\_\_\_ on \_\_\_*\_\_\_\_\_\_\_\_\_* in the *\_\_(Hospital)\_\_\_\_\_\_\_\_\_* *(please indicate the ED or Inpatient Unit)*. In my clinical evaluation of \_\_\_\_\_\_\_\_\_, I also obtained information regarding the patient from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (*Please indicate appropriate sources of information – including but not limited to: clinical staff members within the hospital or other locations, reviewing care management notes from other facilities through shared ENS/EMR platform, family members, EMS, patient’s medical record, other.)*

\_\_\_\_\_\_\_\_\_\_\_ arrived *(Provide the applicable* ***Presentation*** *information from the checklist, including both the method of arrival and the reason for the current visit including the existing medical conditions from the clinical evaluation.)*

\_\_\_\_\_ has been previously treated for *(Provide any past evaluation/treatment information from the checklist.)*

\_\_\_\_\_\_\_\_\_ has a serious health condition(s) that is/are directly affected by his/her *(alcohol and/or substance use disorder).* Based on my review and in my opinion, \_\_\_\_\_\_\_’s inability to refrain from *(alcohol and/or substance use disorder)* use puts him/her at significant risk of disability and/or death. In addition to the general risks of regular intoxication, his/her existing medical conditions put him/her at imminent risk of significant medical harm. Ongoing lack of treatment for each of these carries potentially fatal consequences, made more likely by regular *(alcohol and/or substance use disorder)*.

Attached to this letter is a detailed list of laboratory test results, the clinical notes outlining the current course of treatment in the hospital, and the proposed discharge plan.

In my opinion, \_\_\_\_\_\_\_\_\_\_\_\_ requires commitment to a facility for treatment of *(alcohol and/or substance use disorder)*. Without treatment, it is my opinion that \_\_\_\_\_\_\_\_\_ is at imminent and serious risk of disability and/or death.

\_\_\_\_\_\_\_\_\_\_\_\_ has been medically cleared *(please indicate medical and/or psychiatric)* and is available for transport to court at this time.

For further information about the care and treatment provided at the hospital, please contact *(Please indicate the name, phone or pager number of the treating clinician or of another physician who can answer patient related questions and clarify the reason for the petition if the treating clinician is not available post-shift.)*

Signed under the pains and penalties of perjury,

(Treating Physician (MD/DO))