

Cover Sheet to Agency for Health Care Administration

This form must be completed, attached to each of the forms listed below and sent by the receiving/treatment facility or service provider within one working day of the person's arrival at the facility/provider or upon the facility/provider's receipt of a court order for involuntary inpatient placement or involuntary outpatient placement to:

BA Reporting Center
FMHI – MHC 2637
13301 Bruce B. Downs Blvd.
Tampa, FL 33612-3807

Questions about form completion and receipt may be addressed to bareporting@fmhi.usf.edu or by calling 813-974-9665.
Additional information about form completion can be found at <http://bakeract.fmhi.usf.edu>.

Check the box to indicate the type of form attached:

- | | |
|---|---|
| <input type="checkbox"/> Ex-Parte Order for Involuntary Examination | <input type="checkbox"/> Involuntary Inpatient Placement Order |
| <input type="checkbox"/> Report of Law Enforcement Officer Initiating Involuntary Examination | <input type="checkbox"/> Involuntary Outpatient Placement Order |
| <input type="checkbox"/> Certificate of Professional Initiating Involuntary Examination | <input type="checkbox"/> Continued Involuntary Outpatient Placement Order |

Identifying Information about the person (if known)

Person's Name (Please Print): _____

Florida County of Residence: _____ or State (if not FL) _____

Florida Zip Code of Residence: _____ Homeless (no zip code)

Social Security Number: _____ - _____ - _____

Date of Birth -- --

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Gender	Race	Hispanic Origin?	Immediately prior to this exam and/or placement, was the person in:
<input type="checkbox"/> Female	<input type="checkbox"/> Caucasian/White	<input type="checkbox"/> Yes	Yes No Answer for Adults ONLY (18 and over)
<input type="checkbox"/> Male	<input type="checkbox"/> African-American/Black	<input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> A nursing home?
	<input type="checkbox"/> Asian		<input type="checkbox"/> <input type="checkbox"/> An assisted living facility?
	<input type="checkbox"/> Other		<input type="checkbox"/> <input type="checkbox"/> Jail (i.e., sent for examination from jail)?
			Yes No Answer for Children Only (under 18)
			<input type="checkbox"/> <input type="checkbox"/> Department of Juvenile Justice Custody?
			<input type="checkbox"/> <input type="checkbox"/> DCF custody (such as shelter or foster care)?
			<input type="checkbox"/> <input type="checkbox"/> School?

Name of Provider:	<i>OR</i>	FMHI Assigned Provider #
Address:		
Provider Phone Number (_____) _____ - _____ ext _____		
Name of Person Completing Form (Please Print): _____		
Date Person Arrived at Facility: _____ Date Mailed to BA Reporting Center: _____		

By Authority of s. 394.463, Florida Statutes
CF-MH 3118, Sept 06 (obsoletes previous editions) (Mandatory Form but name/address/phone number/FMHI number for provider may be preprinted.)