# Authorization of Ambulance/Secure Transportation Services under the Involuntary Treatment Act (ITA)

## *Use this form for mental health transports and for substance use disorder transports.*

|  |  |  |
| --- | --- | --- |
| Client name      | Date of transport      | County of residence      |
| Address      | City      | State      | ZIP Code      |
| [ ]  Homeless | [ ]  Transient | [ ]  Other:  | Gender[ ]  Male [ ]  Female  |
| Birthdate (MM/DD/YYYY)      | SSN      | ProviderOne ID      |

## *The section below must be completed by a Designated Crisis Responder (DCR).*

|  |
| --- |
| **Reason for detention** (check all that apply):[ ]  Danger to self [ ]  Danger to others [ ]  Gravely disabled [ ]  LRA revocation [ ]  Danger to property |
| **ITA status at time of transport:** [ ]  Detained [ ]  Committed [ ]  LRA/CR revoked *LRA = Less restrictive alternative/CR = Conditional release* |
| Date of detention      | Destination facility name      | Destination county      |
|  |  |  |  |
| **DCR Attestations**By signing below, I certify that the following statements are true:* The above-named individual has been assessed by a DCR and found to meet criteria for detention/revocation/commitment, per RCW 71.05, or RCW 71.34.
* I am authorized to take said individual or cause said individual to be taken into custody and placed into a treatment facility or crisis center, per RCW 71.05.150(4), or RCW 71.05.153(1).
* The individual named above has been detained, committed, or is being returned to the hospital by a petition for detention/revocation or an order of commitment pursuant to RCW 71.05, or RCW 71.34.
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| Signature of DCR | Date      |
| Name of DCR (print)      | BHO (including county)      |

## PROVIDER: Attach a completed copy to your claim; keep the original in the client’s file.