Washington State Department of Social & Health Services
Transforming lives

BEHAVORIAL HEALTH ADMINISTRATION (BHA)

Removal and Transport Directive

Washington State Health Care Authority

Date: _____

TO: **American Medical Response (AMR)** Email: _____

FROM (FNP Region): _____

Authorized Person Requesting: _____ Phone Number: (_____) _____

Section 1. Client Information			
LAST NAME	FIRST NAME	CIN NUMBER	DATE OF BIRTH
ADDITIONAL CONTACT	PHONE NUMBER (WITH AREA CODE)	ORGANIZATION	
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What is the mobility status of the client (i.e. wheelchair, cane)?			
PICK-UP ADDRESS (EXACT ADDRESS / ENTRANCE)			
TRANSPORT START TIME : ☐ AM ☐ PM	DATE	TRANSPORT END TIME : ☐ AM ☐ PM	DATE
DROP-OFF ADDRESS (EXACT ADDRESS / ENTRANCE)			
SPECIAL NEEDS / COMMENTS			

Section 2. Certification

☐ Client needs transportation to an alternate location as determined by the OCRP Program Director / DSHS Forensic Navigator / HCA in its authority granted under RCW 10.77.086 (i) and RCW 10.77.088 (i) which permits the signed Outpatient Competency Restoration order to be provided for authorization of secure transport and detention of client:

RCW 10.77.086 (i) /RCW 10.77.088 (i): *"The department may authorize a peace officer to detain the defendant into emergency custody for transport to the designated inpatient competency restoration facility. If medical clearance is required by the designated competency restoration facility before admission, the peace officer must transport the defendant to a crisis stabilization unit, evaluation and treatment facility, emergency department of a local hospital, or triage facility for medical clearance once a bed is available at the designated inpatient competency restoration facility. The signed outpatient competency restoration order of the court shall serve as authority for the detention of the defendant. The signed outpatient competency restoration order of the court shall serve as authority for the detention of the defendant under this subsection".*

SIGNATURE	DATE	PRINT NAME

Section 3. AMR Transport Confirmation

SIGNATURE	DATE	PRINT NAME

Section 4. Receiving Facility Confirmation

SIGNATURE	DATE	PRINT NAME

Please bill this transport to the: Office of Forensic Mental Health Services
4450 10th Ave. SE
Lacey WA 98503
DSHS Contract Code: 1000XC-12