

BEHAVIORAL HEALTH ADMINISTRATION (BHA)  
**Removal and Transport Directive**

Date: \_\_\_\_\_

TO: **Olympic Ambulance Services** 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	DATE	TRANSPORT END TIME	DATE
: <input type="checkbox"/> AM <input type="checkbox"/> PM		: <input type="checkbox"/> AM <input type="checkbox"/> PM	
DROP-OFF ADDRESS (EXACT ADDRESS / ENTRANCE)			
SPECIAL NEEDS / COMMENTS			
Section 2. Certification			
<input type="checkbox"/> 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: <i><b>RCW 10.77.086 (i) /RCW 10.77.088 (i):</b> "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".</i>			
SIGNATURE	DATE	PRINT NAME	
Section 3. Olympic Ambulance Services Transport Confirmation			
SIGNATURE	DATE	PRINT NAME	
Section 4. Receiving Facility Confirmation			
SIGNATURE	DATE	PRINT NAME	

Please bill this transport to the: Department of Social and Health Services, OFMHS  
 Attention: Samantha Anderson  
 Email: [samantha.anderson2@dshs.wa.gov](mailto:samantha.anderson2@dshs.wa.gov)  
 PO Box 45330  
 Olympia WA 98504-5330