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| Transforming Lives.png | BEHAVORIAL 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**:** [ ]  AM [ ]  PM  | TRANSPORT END TIME DATE**:** [ ]  AM [ ]  PM  |
| 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. 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  PO Box 45330 Olympia WA 98504-5330 |