**STATE OF NORTH CAROLINA**
Department of Health and Human Services
Division of Mental Health, Developmental Disabilities, and Substance Use Services

County _____
Client Record # _____
File # _____

# EVALUATION FOR ADMISSION / CONTINUED STAY

Voluntary Minors and Incompetent Adults in Restrictive 24-Hour Facilities

○ Minor ○ Incompetent Adult

| **Name** | **DOB** | **Age** | **Sex** | **Race** | **Hispanic?** | **M.S.** |
|---|---|---|---|---|---|---|
| **Address** *(Street, Apt., Route, or Box Number; City, State, Zip - Use Facility Address after 1 Year in Facility)* | | | | | **County** | |
| | | | | | **Phone** | |
| **Legally Responsible Person (Name)** | | **Relationship** | | | | |
| **Address** *(Street, Apt., Route or Box Number; City, State, Zip)* | | | | | **County** | |
| | | | | | **Phone** | |

The above-named minor / incompetent adult was examined on (mm/dd/yyyy) at ○ a.m. ○ p.m. in _____. The results of the examination are as follows:

DESCRIPTION OF FINDINGS (Include indications for mental illness or substance abuse and need for further treatment or evaluation. Also include information provided by family members regarding the individual's need for further treatment).

NOTABLE PHYSICAL CONDITIONS:

CURRENT MEDICATIONS (Medical and Psychiatric):

(OVER)

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IMPRESSION / DIAGNOSIS:

As a result of my examination, it is my opinion that the above-named individual:

○ IS ○ IS NOT: ○ mentally ill or ○ a substance abuser
○ IS ○ IS NOT in need of further evaluation by the facility
○ DOES NEED OR CAN BENEFIT ○ DOES NOT NEED OR CANNOT BENEFIT from the care, treatment, habilitation or rehabilitation available at the facility

RECOMMENDATION FOR DISPOSITION:

○ Admit for treatment / rehabilitation (applies to initial hearings only)
○ Admit for further diagnosis and evaluation not to exceed an additional 15 days following the initial hearing
○ Continue treatment for days (applies to rehearings only)
○ Other (Specify)

| | |
|---|---|
| _____<br>Signature / Title - Responsible Professional<br><br>_____<br>Print Name of Responsible Professional<br><br>_____<br>Facility Name and Address<br><br>_____<br>City, State, Zip<br><br>_____<br>Telephone Number | This is to certify that this is a true and exact copy of the Evaluation For Admission / Continued Stay.<br><br>_____<br>Original Signature - Record Custodian<br><br>_____<br>Title<br><br>_____<br>Facility Name and Address<br><br>_____<br>Date<br><br>NOTE: Only copies to be introduced as evidence need to be certified. |

Original: Medical Record
cc: Clerk of Superior Court where facility is located
Respondent's Attorney
State's Attorney