STATE OF NORTH CAROLINA **EVALUATION FOR ADMISSION / CONTINUED STAY**
Department of Health and Human Services
Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

County _____ **(Restrictive 24-hour Facilities)** File # _____
Client Record # _____ **Voluntary Minors and Incompetent Adults** File # _____

NAME OF MINOR OR INCOMPETENT ADULT	AGE	BIRTHDATE	SEX	RACE	M.S.

ADDRESS (Street, Apt., Route, Box Number, City, State, Zip - Use facility address after 1 year in facility)	County
	Phone
LEGALLY RESPONSIBLE PERSON (Name and Address)	Relationship
	Phone

The above-named ☐ minor ☐ incompetent adult was examined on _____, 20____, at_____ o'clock _____.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).

(OVER)

DESCRIPTION OF FINDINGS (continued):

NOTABLE PHYSICAL CONDITIONS:

CURRENT MEDICATIONS (Medical and Psychiatric):

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) _____

_____
Signature / Title - Responsible Professional

_____
Print Name of Responsible Professional

_____
Facility Name and Address

_____
City, State, Zip

_____
Telephone Number

This is to certify that this is a true and exact copy of the Evaluation For Admission / Continued Stay.

_____
Original Signature - Record Custodian

_____
Title

_____
Facility Name and Address

_____
Date

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