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

REQUEST TO RETURN ESCAPEE OR CONDITIONAL RELEASEE

DATE: _____ TO: _____ (Sheriff/Law Enforcement Officer) FROM: _____ (Facility) (Where Facility is Located)

Patient's name: _____ **Also known as**_____ **Hospital Number:** _____ **SS#:** _____

Last known home address: _____ **Admit date**: _____

This is to notify you that the above named patient from _____ (home county) **County** ❑ **ESCAPED on** _____
❑ **BREACHED THE CONDITION OF HIS/HER RELEASE ON** _____

The patient is:
- ❑ Under involuntary commitment
  - ❑ following being charged with a violent crime and found not guilty by reason of insanity (**NGRI**) or incapable of proceeding (**HB 95)**
- ❑ A competent adult voluntarily admitted and in my opinion is reasonable foreseeable that:
  1) he/she may cause physical harm to others or himself;
  2) he/she may cause damage to property
  3) he/she may commit a felony or a violent misdemeanor; or
  4) the health or safety of the client may be endangered unless he/she is immediately returned to the facility
- ❑ A minor or incompetent adult voluntarily admitted
- ❑ Admitted pending a judicial hearing
- ❑ Under conditional release from the facility
- ❑ Involuntarily committed or voluntarily admitted and under a **DETAINER** issued by _____

Patient was last seen: Date: _____ Time: _____ Wearing: _____

Location:
❑ Activity Area ❑ Activity Trip ❑ Bathroom ❑ Bedroom
❑ Clinic ❑ Courtroom ❑ Courtyard ❑ Dayroom
❑ Dining room ❑ Elevator ❑ Grill/Canteen ❑ Grounds
❑ Gym ❑ Hallway ❑ Medical Transport ❑ Stairway
❑ Work Activity ❑ Unknown ❑ Other _____

*****Note*** Is the above named patient to be taken into custody and returned to the above named facility pursuant to G.S. 122C-205?** ❑ **Yes** ❑ **No** (see reverse for instructions)

PATIENT IDENTIFYING INFORMATION

Race _____ **Sex** ___ **Place of birth (state)**_____ **Date of birth** _____ **Age** ____ **Height** _____ **Weight** _____

Eye color _____ **Hair color** _____ **Hair style** _____ **Skin tone** _____

Scars/Marks/Tattoos _____ Facial features _____

Build _____ Gait _____ Other distinguishing features _____

Drivers license #: _____ Driver's lic state: _____ Date of expiration: _____

Patient has vehicle at hospital ❑ yes ❑ no If yes, vehicle license number: _____ Vehicle lic state: _____

Vehicle lic year _____ Type of vehicle: _____ Vehicle ID #: _____

Vehicle year: _____ Vehicle make: _____ Vehicle style:_____ Vehicle color:_____

Dangerous to self ❑ no ❑ yes (specify) _____

Dangerous to others: ❑ no ❑ yes (specify)_____

Avoids people ❑ no ❑ yes **Medical Conditions/Impairments**:_____ **Needs further treatment**: ❑ yes ❑ no

ADDITIONAL INFORMATION

Unit: _____ **Attending MD**:_____ **Census**:_____ **Total # staff on duty**:_____ **Total # staff present:** _____

Was this a repeat elopement for this admission? ❑ no ❑ yes (list others) _____

Privilege Category:_____ **Was discharge planned within 5 days of elopement**? ❑ no ❑ yes (when) _____

Level of supervision at time of elopement: ❑ Unsupervised pass (type/length_____ ❑ Supervised pass
❑ Escape precautions ❑ 1:1 Observation ❑ Constant Observation ❑ Suicide Precautions

Legally Responsible Party/Next of Kin/Guardian: _____Relationship:_____
Address: _____ County: _____ Phone: _____

Locations where patient has been found when missing from unit: _____

Additional information that is reasonably necessary to assure the expeditious return of the client and protect the patient and/or the general public (including possible locations and contacts): _____

Account of events:_____

Signature of Authorizing Physician	**Printed name**	**Date**

DISTRIBUTION WHEN REQUEST TO RETURN IS ISSUED:

Nursing Staff:
- HIM (original copy)
- Initial examiner if involuntarily committed
- Any law enforcement office notified
- Official placing patient on detainer
- Area program (if appropriate)
- Clerk of Superior Court in county of commitment
- Risk management coordinator
- Next of kin/legally responsible party

Instructions for completion of Request to Return Form

- Items in **Bold Print** are items that are required to be completed.

- Must indicate **Yes** or **No** if a warrant is to be issued **pursuant to G.S. 122C-205**
  - **Yes** if a warrant to return the patient is to be issued
  - **No** if the patient is discharged or a warrant is not issued for patient's return

- If a warrant is not issued or the patient is discharged, this form must be completed and faxed to the Risk Management Coordinator (per policy S.C.P.M. U-1)