

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 <i>(Street, Apt., Route, or Box Number; City, State, Zip - Use Facility Address after 1 Year in Facility)</i>					County	
					Phone	
Legally Responsible Person (Name)			Relationship			
Address <i>(Street, Apt., Route or Box Number; City, State, Zip)</i>					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)

<p>_____ Signature / Title - Responsible Professional</p> <p>_____ Print Name of Responsible Professional</p> <p>_____ Facility Name and Address</p> <p>_____ City, State, Zip</p> <p>_____ Telephone Number</p>	<p>This is to certify that this is a true and exact copy of the Evaluation For Admission / Continued Stay.</p> <p>_____ Original Signature - Record Custodian</p> <p>_____ Title</p> <p>_____ Facility Name and Address</p> <p>_____ Date</p> <p>NOTE: Only copies to be introduced as evidence need to be certified.</p>
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Original: Medical Record
cc: Clerk of Superior Court where facility is located
Respondent's Attorney
State's Attorney