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

REQUEST TO RETURN ESCAPEE OR CONDITIONAL RELEASEE

Date: To: _____ From: _____
(Sheriff or other Law Enforcement Officer) (Facility, Location)

Name	**Also Known As**	**Facility License #**	**SS#**

Address *(Street, Apt., Route, or Box Number; City, State, Zip - Use Facility Address after 1 Year in Facility)*	**County**
	Admit Date

This is to notify you that the above-named patient from _____ County
◯ **Escaped on** ◯ **Breached their condition of 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
◯ A competent adult voluntarily admitted and in my opinion it is reasonably foreseeable that
◯ This individual may cause physical harm to self or others,
◯ This individual may cause damage to property,
◯ This individual may commit a felony or a violent misdemeanor, or
◯ The health or safety of this individual may be endangered if not 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	◯ Clinic	◯ Dining Room	◯ Gym	◯ Work Activity
◯ Activity Trip	◯ Courtroom	◯ Elevator	◯ Hallway	◯ Unknown
◯ Bathroom	◯ Courtyard	◯ Grill/Canteen	◯ Medical Transport	◯ Other _____
◯ Bedroom	◯ Dayroom	◯ Grounds	◯ Stairway	

*****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/Gender** _____ 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 _____
Dangerous to Self? ◯ No ◯ Yes (specify) _____
Dangerous to Others? ◯ No ◯ Yes (specify) _____
Avoids People? ◯ No ◯ Yes **Medical Conditions/Impairments** _____
Needs Further Treatment? ◯ Yes ◯ No **Was discharge planned within 5 days of elopement?** ◯ No ◯ Yes (when) _____

ADDITIONAL INFORMATION

Attending MD _____ **Assigned Unit** _____ **Census Count**: ____ **# of Staff on Duty:** ____
# of Staff Present: _____ **Is this a repeat elopement for this admission?** ◯ No ◯ Yes (list other dates) _____
Level of supervision at time of elopement: ◯ Unsupervised Pass (type/length) _____ ◯ Supervised Pass
◯ Escape Precautions ◯ 1:1 Observation ◯ Constant Observation ◯ Suicide Precautions
Legally Responsible Person/Next of Kin/Guardian: _____ Relationship _____
Address: _____ County: _____ Phone: _____
Driver License # _____ Issuing State: _____ Date of Expiration: Patient has vehicle at hospital? ◯ Yes ◯ No
Vehicle License # _____ Vehicle Make & Model _____ Vehicle Color _____
Locations where patient has been found when missing from unit: _____
Additional information that is reasonably necessary to assure the expeditious return of the patient 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) Official placing patient on detainer Risk Management Coordinator
LME-MCO (if appropriate) Next of kin/legally Responsible Party Any law enforcement office notified
Initial examiner if involuntarily committed Clerk of Superior Court in county of commitment

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

- FOR STATE-OPERATED FACILITIES: 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)