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

County _____
Client Record # _____
File # _____

FIRST EXAMINATION FOR INVOLUNTARY COMMITMENT

Name of Respondent	**DOB**	**Age**	**Sex**	**Race**	**M.S.**

Address *(Street or Box Number)*	**City**	**State**	**Zip**	**County**	**Phone**

Legally Responsible Person or Next of Kin (Name)	**Relationship**

Address *(Street or Box Number)*	**City**	**State**	**Zip**	**County**	**Phone**

Petitioner (Name)	**Relationship**

Address *(Street or Box Number)*	**City**	**State**	**Zip**	**County**	**Phone**

EXAMINATION INFORMATION

The First-Level examination and evaluation for the above-named respondent:

was conducted on _____/_____/_____ *(MM/DD/YYYY)* at _____:_____ ○ **A.M.** ○ **P.M.**

was conducted:
○ In person at the following facility _____ OR ○ Via telemedicine technology

Included in the examination was an assessment of the respondent's:

☐ (1) Current and previous mental illness and intellectual disability including, if available, previous treatment history; (2) Dangerousness to self or others as defined in G.S.122C-3 (11*); (3) Ability to survive safely without inpatient commitment, including the availability of supervision from family, friends, or others; and (4) Capacity to make an informed decision concerning treatment.

☐ (1) Current and previous substance abuse including, if available, previous treatment history; and (2) Dangerousness to self or others as defined in G.S.122C-3 (11*).

The following findings and recommendations are made based on this examination^:

SECTION I – CRITERIA FOR COMMITMENT

It is my opinion that the respondent meets the criteria for the selected type of commitment as the respondent is:

☐ **Inpatient**
(1st Exam – Commitment Examiner, eligible Psychologist or Physician)
- ☐ An individual with a mental illness;
- ☐ Dangerous to:
  - ☐ Self *or*
  - ☐ Others;
- ☐ In addition to having a mental illness is also intellectually disabled;
- ☐ None of the above

☐ **Outpatient** *(1st Exam – Commitment Examiner, eligible Psychologist or Physician)*
- ☐ An individual with a mental illness;
- ☐ Capable of surviving safely in the community with available supervision;
- ☐ Based upon the respondent's treatment history, the respondent is in need of treatment in order to prevent further disability or deterioration which would predictably result in dangerousness as defined by G.S. 122C-3 (11*);
- ☐ Current mental status or the nature of his/her illness limits or negates his/her ability to make an informed decision to seek treatment voluntarily or comply with recommended treatment;
- ☐ None of the above

☐ **Substance Abuse**
(1st Exam – LCAS CE, eligible Psychologist or Physician)
- ☐ A Substance Abuser;
- ☐ Dangerous to:
  - ☐ Self *or*
  - ☐ Others;
- ☐ None of the above

^*For telemedicine evaluations only:* ☐ I certify to a reasonable degree of medical certainty that the results of the examination via telemedicine were the same as if I had been personally present with the respondent **OR** ☐ The respondent needs to be taken for a face-to-face evaluation. *(*Statutory definitions begin on page 3)*

Name of Respondent:	DOB:

SECTION II – DESCRIPTION OF FINDINGS

Clear description of findings (findings for each criterion checked in Section I must be described):

Impression/Diagnosis:

HEALTH SCREENING

A health screening (N.C. G.S. § 122C-3(16a)) does not constitute a medical evaluation† and should be completed at the same location as the first examination or by utilizing telemedicine equipment and procedures (N.C.G.S.§ 122C-263(a1)).

☐ **Check box & sign to attest that the health screening is being replaced by a medical evaluation†** skip to Section III

_____ _____
Signature Printed Name, Credentials, Date & Time

Vital Signs

BP _____ HR _____ RR _____ Temp _____ Date & Time _____
If person taking vitals is different than person completing this form, sign/print name & credentials below:

_____ _____
Signature Printed Name, Credentials, Date & Time

Known/reported medical problems (diabetes, hypertension, heart attacks, sickle cell anemia, asthma, etc.):

Known/reported allergies:

Known/reported current medications (please list):

If ANY of the below are present, check box and send respondent to an <u>Emergency Department</u> by the most appropriate means:

☐ Chest pain or shortness of breath
☐ Suspected overdose on substances or medications within the past 24 hours (including acetaminophen)
☐ Presence of severe pain (e.g. abdominal pain, head pain)
☐ Disoriented, confused, or unable to maintain balance
☐ Head trauma or recent loss of consciousness
☐ Recent physical trauma or profuse bleeding
☐ New weakness, numbness, speech difficulties or visual changes
☐ Other Rationale (including medical evaluation indicated, but not available at current location):

_____

☐ None of the above

Name of Respondent:	DOB:

IF ANY of the below are present, check box and consult° with medical provider‡ within one hour:

☐ Age < 12 or > 65 years old
☐ Systolic BP > 160 or < 100 and/or diastolic > 100 or < 60
☐ Heart Rate >110 or < 55 bpm
☐ Respiratory Rate > 20 or < 12 breaths per minute
☐ Temperature > 38.0 C (100.4 F) or < 36.0 C (96.8 F)
☐ Known diagnosis of diabetes and not taking prescribed medications
☐ Recent seizure or history of seizures and not taking seizure medications
☐ Known diagnosis of asthma or chronic obstructive pulmonary disease and not taking prescribed medications
☐ Visible or reported open sores, wounds, or active bleeding
☐ Severe constipation **or** vomiting **or** diarrhea
☐ Painful urination or new onset incontinence
☐ Known or suspected pregnancy
☐ Used substances of abuse, (e.g. alcohol, opiates, benzodiazepines, cocaine, etc.) or prescription medication not prescribed to them, within the past 48 hours
☐ Other Rationale:

_____

☐ None of the above

_____ Signature of Person Completing Health Screening

_____ Printed Name, Credentials, Date & Time

†***DEFINITION OF Medical Evaluation****: Medical history and physical exam performed by a medical provider*

‡***DEFINITION OF Medical Provider****: MD, DO, PA, or NP licensed in N.C.*

°*Consultation can be via telephone, telemedicine or in person*

***STATUTORY DEFINITIONS for Form No. DMH 5-72-19**

Commitment examiner. - A physician, an eligible psychologist, or any health professional or mental health professional who is certified under G.S. 122C-263.1 to perform the first examination for involuntary commitment described in G.S. 122C-263(c) or G.S. 122C-283(c).

Dangerous to others. - Within the relevant past, the individual has inflicted or attempted to inflict or threatened to inflict serious bodily harm on another, or has acted in such a way as to create a substantial risk of serious bodily harm to another, or has engaged in extreme destruction of property; and that there is a reasonable probability that this conduct will be repeated. Previous episodes of dangerousness to others, when applicable, may be considered when determining reasonable probability of future dangerous conduct. Clear, cogent, and convincing evidence that an individual has committed a homicide in the relevant past is prima facie evidence of dangerousness to others.

Dangerous to self. - Within the relevant past the individual has done any of the following: (1) acted in such a way as to show all of the following: (I) The individual would be unable without care, supervision, and the continued assistance of others not otherwise available, to exercise self-control, judgment, and discretion in the conduct of the individual's daily responsibilities and social relations or to satisfy the individual's need for nourishment, personal or medical care, shelter, or self-protection and safety. (II) There is a reasonable probability of the individual suffering serious physical debilitation within the near future unless adequate treatment is given. A showing of behavior that is grossly irrational, of actions that the individual is unable to control, of behavior that is grossly inappropriate to the situation, or of other evidence of severely impaired insight and judgment shall create a **prima facie** inference that the individual is unable to care for himself or herself. (2) The individual has attempted suicide or threatened suicide and that there is a reasonable probability of suicide unless adequate treatment is given. (3) The individual has mutilated himself or herself or attempted to mutilate himself or herself and that there is a reasonable probability of serious self-mutilation unless adequate treatment is given. NOTE: Previous episodes of dangerousness to self, when applicable, may be considered when determining reasonable probability of physical debilitation, suicide, or self-mutilation.

Health screening. - An appropriate screening suitable for the symptoms presented and within the capability of the entity, including ancillary services routinely available to the entity, to determine whether or not an emergency medical condition exists. An emergency medical condition exists if an individual has acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the individual's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Name of Respondent:	DOB:

Local management entity/managed care organization or **LME/MCO**. - A local management entity that is under contract with the Department to operate the combined Medicaid Waiver program authorized under Section 1915(b) and Section 1915(c) of the Social Security Act.

Local management entity or **LME.** - An area authority.

Mental illness. - When applied to an adult, an illness which so lessens the capacity of the individual to use self-control, judgment, and discretion in the conduct of the individual's affairs and social relations as to make it necessary or advisable for the individual to be under treatment, care, supervision, guidance or control. When applied to a minor, a mental condition, other than an intellectual disability alone, that so lessens or impairs the minor's capacity to exercise age adequate self-control and judgment in the conduct of the minor's activities and social relationships so that the minor is in need of treatment.

Substance abuser. - An individual who engages in the pathological use or abuse of alcohol or other drugs in a way or to a degree that produces an impairment in personal, social, or occupational functioning. Substance abuse may include a pattern of tolerance and withdrawal.

SECTION III – RECOMMENDATION FOR DISPOSITION

☐ **Inpatient Commitment** for_____days *(respondent must have a mental illness **and** dangerous to self or others)*

☐ **Outpatient Commitment** *(respondent must meet **ALL** of the first four criteria outlined in Section I, **Outpatient**)*
Proposed Outpatient Treatment Center or Physician: (Name) _____
(Address & Phone Number) _____

☐ **Substance Abuse Commitment** *(respondent must meet both criteria outlined in Section I, **Substance Abuse**)*
☐ Release respondent pending hearing – Referred to: _____
☐ Hold respondent at 24-hour facility pending hearing – Facility:_____

☐ Respondent or Legally Responsible Person Consented to Voluntary Treatment

☐ Respondent was held at first evaluation site pending placement at a 24-hour facility and no longer meets criteria for inpatient commitment:
☐ Terminate proceedings and release respondent
☐ Recommend outpatient commitment
Proposed Outpatient Treatment Center or Physician: (Name) _____
(Address & Phone Number) _____

☐ Release Respondent and Terminate Proceedings (insufficient findings to indicate that respondent meets commitment criteria)

_____
Signature of Commitment Examiner

_____
Print Name of Examiner

Credentials *(check one):* ☐ MD/DO ☐ Eligible Psychologist ☐ PA
☐ NP *(Master's-level or Higher)* ☐ LCSW ☐ LCMHC ☐ LMFT
☐ LCAS *(Substance Abuse Evaluation Only)*

_____
Address of Facility

_____
City and State

_____
Telephone Number

This is to certify that this is a true and exact copy of the Examination and Recommendation for Involuntary Commitment

_____
Original Signature – Record Custodian

_____
Title

_____
Address of Facility

_____
Date

CC: Clerk of Superior Court where petition was initiated; Clerk of Superior Court where 24-hour facility is located or where outpatient treatment is supervised; Respondent or Respondent's Attorney and State's Attorneys, when applicable; Proposed Outpatient Treatment Center or Physician (Outpatient Commitment); Area Facility/Physician (Substance Abuse Commitment). NOTE: If it cannot be reasonably anticipated that the clerk will receive the copies within 48 hours of the time that it was signed, the examiner shall communicate his findings to the clerk by telephone.