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**: _____

Hospital Unit/Bldg/Ward _____

This is to notify you that the above named patient from _____ **County** ❑ **ESCAPED on** _____
(home county)
❑ **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	❑ Clinic	❑ Dining room	❑ Gym	❑ Work Activity
❑ Activity Trip	❑ Courtroom	❑ Elevator	❑ Hallway	❑ Unknown
❑ Bathroom	❑ Courtyard	❑ Grill/Canteen	❑ Medical Transport	❑ Other _____
❑ Bedroom	❑ Dayroom	❑ Grounds	❑ Stairway	

The above named patient is to be taken into custody and returned to the above named facility pursuant to G.S. 122C-205.

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 _____

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

Type of vehicle: _____ 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

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): _____

_____

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

DISTRIBUTION WHEN REQUEST TO RETURN IS ISSUED:

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