Atrium Health
Wake Forest Baptist

IVC and Admission Forms

Let's start here:

My name is _____ and I'm a MD_____
at Wake Forest Baptist Medical Center_____.

Then select an option below:

Involuntary Commitment (IVC)

Adult Voluntary

Child Voluntary

Second Opinion

Change of Commitment

Reset form

Important! Download and open this file in Adobe Reader only.
Errors will occur if run within your browser (Chrome, Firefox, etc.)

ezIVC

Ver 3.0.1 - updated Aug 2024
Created by Michael Vollmer, PA-C
[feedback] [check for updates]

Although this **petition** form is a necessary part of a standard IVC, it's most efficient to complete the first examination form first, as everything will automatically back-fill.

STATE OF NORTH CAROLINA

File No.

Forsyth County

In The General Court Of Justice
District Court Division

IN THE MATTER OF

Name And Address Of Respondent

NC

AFFIDAVIT AND PETITION FOR INVOLUNTARY COMMITMENT

G.S. 122C-261, 122C-281

Social Security No. Of Respondent (if available)	*Date Of Birth*	*Drivers License No. Of Respondent*	*State*

I, the undersigned affiant, being first duly sworn, and having sufficient knowledge to believe that the respondent is a proper subject for involuntary commitment, allege that the respondent is a resident of, or can be found in the above named county, and:

(check all that apply)

☒ 1. has a mental illness and is dangerous to self or others or has a mental illness and is in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness.

☐ in addition to having a mental illness, respondent also has an intellectual disability.

☐ 2. is a substance abuser and dangerous to self or others.

The facts upon which this opinion is based are as follows: (*State facts, not conclusions, to support ALL blocks checked.*)

Name And Address Of Nearest Relative Or Guardian		*Name And Address Of Person Other Than Petitioner Who May Testify*	
Home Telephone No.	*Business Telephone No.*	*Home Telephone No.*	*Business Telephone No.*

Petitioner requests the court to issue an order to a law enforcement officer to take the respondent into custody for examination by a person authorized by law to conduct the examination for the purpose of determining if the respondent should be involuntarily committed.

SWORN/AFFIRMED AND SUBSCRIBED TO BEFORE ME

Signature Of Petitioner

Date	*Signature*	*Name And Address Of Petitioner (type or print)*
		Wake Forest Baptist Medical Center | Medical Center Blvd Winston Salem NC 27157

☐ *Deputy CSC* ☐ *Assistant CSC* ☐ *Clerk Of Superior Court* ☐ *Magistrate*

☐ *Notary (use only with commitment examiner petitioner)*	*Date Notary Commission Expires*	*Relationship To Respondent*	
		Commitment Examiner	
SEAL	*County Where Notarized*	*Home Telephone No.*	*Business Telephone No.* (336) 713-5195

Original-File Copy-Hospital Copy-Special Counsel Copy-Attorney General

(Over)

PETITIONER'S WAIVER OF NOTICE OF HEARING

I voluntarily waive my right to notice of all hearings and rehearings in which the Court may commit the respondent or extend the respondent's commitment period, or discharge the respondent from the treatment facility.

Signature Of Witness	*Date* 08/13/2024
	Signature Of Petitioner

NOTE: *"Upon the request of the legally responsible person or the minor admitted or committed, and after that minor has both been released and reached adulthood, the court records of that minor made in proceedings pursuant to Article 5 of [Chapter 122C] may be expunged from the files of the court." G.S. 122C-54(e).*

Also known as the **First Opinion,** this form is completed by a clinician who has evaluated a patient for IVC.

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

County Forsyth
Patient's MRN# _____
File # _____

FIRST EXAMINATION FOR INVOLUNTARY COMMITMENT

Name of Respondent	**DOB** (mm/dd/yyyy)	**Age**	**Sex**	**Race**	**M.S.**

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

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

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

Petitioner (Name) I'm not the petitioner	**Relationship**
	Commitment Examiner

Address *(Street or Box Number)*	**City**	**State**	**Zip**	**County**	**Phone**
Wake Forest Baptist Medical Center | Medical Center Blvd	Winston Salem	NC	27157	Forsyth	(336) 713-5195

EXAMINATION INFORMATION

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

was conducted on 08 / 13 / 2024 *(MM/DD/YYYY)* at _____:00 ◯ **A.M.** ◯ **P.M.**

was conducted: Select
◉ In person at the following facility Wake Forest Baptist Medical Center OR Select ◯ 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

Uncheck all

☐ 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

Almost done! Select one of the options below.

If the patient **is not** already under petition:

Standard IVC process

This is the most common process for involuntary commitment when the IVC process has not been initiated. It will generate a **cover page**, along with the **petition** and the **first examination.** These documents should be sent to the magistrate to request the issuance of a custody order.

Emergency commitment process

This process bypasses the magistrate and is used only when *immediate* hospitalization is required to prevent harm. It prints the **first examination** and the **emergency commitment**, which must be submitted to the Clerk of Court.* This option is generally limited to use by the psychiatry team.

If the patient **is** already under petition:

Uphold petition

This option prints only the **first examination**. Since the patient is already under petition, it should not be repeated. This should be sent to the Clerk of Court.*

Terminate IVC

This option is used if you evaluate a patient already under petition and determine that they do not meet IVC criteria or they can sign in voluntarily. It will print the **first examination** with the correct boxes automatically selected. This should be sent to the Clerk of Court.*

*must be sent to the Clerk of Court in the same county where the petition and custody order originated.

If ANY of the below are present, check box and send respondent to an Emergency Department 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 30 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)*

Wake Forest Baptist Medical Center | Medical Center Blvd
Address of Facility

Winston Salem, NC 27157
City and State

(336) 713-5195
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

_____

Jump to print options

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.

Also known as the **Emergency Certficate** or 24-hour hold form, this process bypasses the magistrate and acts as the custody order, allowing for immediate transfer to an inpatient psychiatry unit. It must be notorized and used in conjunction with the First Exam.

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

County Forsyth
Patient's MRN# _____
File # _____

SUPPLEMENT TO FIRST EXAMINATION FOR INVOLUNTARY COMMITMENT

CERTIFICATE

To be used in addition to *First Examination for Involuntary Commitment*, Form 5-72-19

The Respondent, _____ requires immediate hospitalization to prevent harm to self or others because:

I certify based upon my examination of the Respondent, which is attached hereto, the Respondent is (check all that apply)

- ☒ **Mentally ill and dangerous to self**
- ☐ **Mentally ill and dangerous to others**
- ☐ **In addition to being mentally ill, has an intellectual disability**

_____
Signature of Commitment Examiner

_____
Print Name of Commitment Examiner, Date and Time

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

Wake Forest Baptist Medical Center
Name of 24-Hour Facility

Medical Center Blvd, Winston Salem, NC 27157
Address, City, State of 24-Hour Facility

(336) 713-5195
Telephone Number of 24-Hour Facility

CC: 24-hour facility
Clerk of Court in county of 24-hour facility

Note: If it cannot be reasonably anticipated that the clerk will receive the copy within 24 hours (excluding Saturday, Sunday and holidays) of the time that it was signed, the commitment examiner shall also communicate the findings to the clerk by telephone.

Seal

NORTH CAROLINA
_____ County

Sworn to and subscribed before me this

_____ day of _____, 20___

_____
Signature of Notary Public

_____
Printed name of Notary Public

My commission expires: _____

Pursuant to G.S. 122C-262 (d), this certificate *shall serve as the Custody Order* required to obtain physical custody and provide transportation as necessary to a 24-hr. facility in accordance with G.S. 122C-251.

Also known as the **Second Opinion,** this form must be completed within 24 hours of admission to an inpatient psychiatry unit. It is not used to initiated an involuntary commitment.

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

County Forsyth
Patient's MRN# _____
File # _____

24 HOUR FACILITY EXAM FOR INVOLUNTARY COMMITMENT∞

Name of Respondent	DOB (mm/dd/yyyy)	Age	Sex	Race	M.S.

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

Legally Responsible Person or Next of Kin (Name)	Relationship

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

Petitioner (Name)	Relationship
I'm not the petitioner	Commitment Examiner

Address *(Street or Box Number)*	City	State	Zip	County	Phone
Wake Forest Baptist Medical Center | Medical Center Blvd	Winston Salem	NC	27157	Forsyth	(336) 713-5195

EXAMINATION INFORMATION

The second examination and evaluation for the above-named respondent:

was conducted on 08 / 13 / 2024 *(MM/DD/YYYY)* at _____:00 ☐ **A.M.** ☐ **P.M.**

was conducted:
☒ In person at the following facility Wake Forest Baptist Medical Center

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
(2nd Exam –Physician ONLY)
- ☒ 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

Uncheck all

☐ Outpatient
(2nd Exam – Physician ONLY)
- ☐ 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
(2nd Exam – Physician if 1st exam was not done by a Physician; Qualified Professional if Physician performed first exam)
- ☐ A Substance Abuser;
- ☐ Dangerous to:
  - ☐ Self *or*
  - ☐ Others;

☐ None of the above

∞ Physician performing the 2nd exam cannot be the same physician that completed the 1st exam or the emergency certificate (G.S. 122C-262 or G.S. 122C-263) (G.S. 122C-266(a)).

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:

***STATUTORY DEFINITIONS for Form No. DMH 5-72-19-2**

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.

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.

Qualified professional. - Any individual with appropriate training or experience as specified by the General Statutes or by rule of the Commission in the fields of mental health or developmental disabilities or substance abuse treatment or habilitation, including physicians, psychologists, psychological associates, educators, social workers, registered nurses, certified fee-based practicing pastoral counselors, and certified counselors 122C-3(31).

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.

Name of Respondent:	DOB:

SECTION III – RECOMMENDATION FOR DISPOSITION

☒ **Inpatient Commitment** for 30 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 does not meet the criteria for commitment but custody order states that the respondent was charged with a violent crime, including a crime involving assault with a deadly weapon, and that he was found incapable of proceeding; therefore, the respondent will not be released until so ordered following the court hearing.

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

_____
Signature of MD/DO

_____
Print Name of MD/DO

_____
Signature of Qualified Professional
(Substance Abuse Evaluation ONLY if 1st evaluation completed by MD/DO)

_____
Print Name of Qualified Professional

Wake Forest Baptist Medical Center | Medical Center Blvd
Address of Facility

Winston Salem, NC 27157
City and State

(336) 713-8100
Telephone Number

Print second opinion

_____
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.

Also known as the **Minor Admit** form, this is completed for every minor admitted to our inpatient unit. It does not need to be notorized or sent anywhere - just place it in the physical chart. The legal guardian of the minor must also sign a voluntary admission form.

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

County Forsyth
Patient's MRN # _____
File # _____

EVALUATION FOR ADMISSION / CONTINUED STAY

Voluntary Minors and Incompetent Adults in Restrictive 24-Hour Facilities

◉ Minor ○ Incompetent Adult

Name	**DOB** (mm/dd/yyyy)	**Age**	**Sex**	**Race**	**Hispanic?**	**M.S.** Single
Address *(Street, Apt., Route, or Box Number; City, State, Zip - Use Facility Address after 1 Year in Facility)* NC					**County** Forsyth **Phone**	
Legally Responsible Person (Name)			**Relationship**			
Address *(Street, Apt., Route or Box Number; City, State, Zip)*					**County** **Phone**	

The above-named minor / incompetent adult was examined on 08/13/2024 (mm/dd/yyyy) at : 00 ○ a.m. ○ p.m. in Wake Forest Baptist Medical Center. 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)

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

County Forsyth
Patient's MRN # _____
File # _____

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)

Print Minor Admit | **Print Minor Admit + Voluntary Form**

Print Minor Admit + Voluntary Form + IVC Reversal

_____
Signature / Title - Responsible Professional

_____
Print Name of Responsible Professional

Wake Forest Baptist Medical Center | Medical Center Blvd
Facility Name and Address

Winston Salem, NC 27157
City, State, Zip

(336) 713-5195
Telephone Number

This is to certify that this is a true and exact copy of the Evaluation For Admission / Continued Stay.

_____
Original Signature - Record Custodian

_____
Title

_____
Facility Name and Address

_____
Date

NOTE: Only copies to be introduced as evidence need to be certified.

Original: Medical Record
cc: Clerk of Superior Court where facility is located
Respondent's Attorney
State's Attorney

Wake Forest®
Baptist Medical Center

Patient Name: _____

MRN: _____

Child and Adolescent Behavioral Health Inpatient Service
REQUEST FOR VOLUNTARY ADMISSION

I understand that my child's psychiatric condition is of such a nature that evaluation and/or treatment in an inpatient facility is warranted. I voluntarily request that my child be admitted to North Carolina Baptist Hospital's Child and Adolescent Behavioral Health Inpatient Service for evaluation and medical treatment by a qualified attending physician and the interdisciplinary treatment team.

I may request that my child be discharged from the child and adolescent inpatient behavioral health unit at any time by signing the REQUEST FOR DISCHARGE FORM. I am aware that the physician has up to 72 hours to evaluate my child's condition for safety for discharge and may initiate involuntarily commitment proceedings if it is determined that continued inpatient care is medically warranted to prevent the patient from harming themselves or others.

I understand that the Behavioral Health unit is a smoke-free environment. In the interest of promoting good health, tobacco products will be prohibited on the unit and during off-unit activities.

All personal belongings will be searched to protect my child or others.

_____	_____	_____
Signature of Legally Authorized Representative/Parent/Guardian	Date	Time
_____	08/13/2024	_____
Signature of Witness	Date	Time

Chart Copy

MISCEL

MR (rev. 09/2017)

Print Minor Admit | Print Minor Admit + Voluntary Form

Also known as the **Change of Commitment** form, this is used to notify the Clerk of Court that the commitment status for a patient currently under IVC is changing. This generally indicates that the patient is being discharged or has signed a voluntary admission form.

Forsyth Clerk of Court (fax): 336-779-6332

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

County Forsyth
Patient's MRN # _____
File # _____

NOTICE OF CHANGE IN COMMITMENT RECOMMENDATION

This form is to be utilized *prior* to an individual's appearance at a court hearing.

Facility Name: Wake Forest Baptist Medical Center

Facility Address (physical location): Medical Center Blvd, Winston Salem, NC 27157

IN THE MATTER OF: Respondent's Name: _____

Initial/Most Recent Date of Recommendation for:

☒ Inpatient ☐ Outpatient ☐ Substance Abuse Commitment _____

TO: Clerk of Superior Court, Forsyth County

This is to certify that the commitment recommendation for the above-named respondent has changed due to the following:

☒ The respondent no longer meets the criteria for inpatient commitment and is unconditionally discharged on 8/9/2024.

☐ The respondent no longer meets the criteria for ☐ outpatient ☐ substance abuse commitment and is unconditionally discharged on _____.

☐ The respondent no longer meets the criteria for inpatient hospitalization but does meet criteria for outpatient commitment. Therefore, the respondent is released from inpatient hospitalization effective _____ with the following instructions pertaining to outpatient commitment: _____

☐ The respondent no longer meets the criteria for outpatient commitment but does meet criteria for inpatient hospitalization. Therefore, outpatient commitment proceedings are being terminated effective _____. Completed *Affidavit and Petition for Involuntary Commitment* and First Exam paperwork reflecting this recommendation accompany this notice / have been submitted to the magistrate or clerk of court.

☐ The respondent or legally responsible person signed a consent for voluntary treatment on _____.

☐ The respondent expired on _____.

☐ The respondent is receiving medical treatment and will not be able to attend a court hearing scheduled on _____. The attending physician has determined that the respondent no longer meets criteria for involuntary commitment, so proceedings are terminated effective _____.

08/13/2024
Date

_____
Name/Title of Commitment Examiner

NOTE:
If current recommendation is *Inpatient Commitment*, signature must be that of Attending Physician.
If current recommendation is *Outpatient* or *Substance Abuse Commitment*, signature must be that of Responsible Professional.

_____
Signature

Print Change of Commitment only

Print Minor Admit + Voluntary Form + IVC Reversal

Wake Forest®
Baptist Medical Center

Patient Name: _____

MRN: _____

Adult Behavioral Health Inpatient Service
REQUEST FOR VOLUNTARY ADMISSION

I understand that my psychiatric condition is of such a nature that evaluation and/or treatment in an inpatient facility is warranted. I voluntarily request to be admitted to North Carolina Baptist Hospital's Inpatient Behavioral Health unit for evaluation and medical treatment by a qualified attending physician and the interdisciplinary treatment team.

I may request to be discharged from the adult inpatient behavioral health unit facility at any time by signing the REQUEST FOR DISCHARGE FORM. I am aware that the physician has up to 72 hours to evaluate my condition for my safety for discharge and may initiate involuntarily commitment proceedings if it is determined that continued inpatient care is medically warranted to prevent me from harming myself or others.

I understand that the Behavioral Health unit is a smoke-free environment. In the interest of promoting good health, tobacco products will be prohibited on the unit and during off-unit activities.

_____ _____ _____
Signature of Legally Authorized Representative/Patient/Guardian Date Time

_____ 08/13/2024 _____
Signature of Witness Date Time

Chart Copy

MR (rev. 09/2017)

Print Adult Voluntary Form

NAME:
DOB: (y) MRN:
PROVIDER:

Atrium Health
Wake Forest Baptist

Date: 08/13/2024

Dear Magistrate:

The attached affidavit/petition and first examination is being provided to you for the purpose of initiating the involuntary commitment of the named respondent, currently located at Wake Forest Baptist Medical Center.

Specific location:

- ☐ Adult emergency department: room _____
- ☐ Pediatric emergency department: room _____
- ☐ Adult inpatient psychiatric unit: room _____
- ☐ Pediatric inpatient psychiatric unit: room _____
- ☐ Other: _____

Print IVC

Return to menu

The respondent is being referred to North Carolina facilities designated under GS § 122C-252 for the custody and treatment of individuals under petition for involuntary commitment. Once we are notified by a 24-hour facility that the respondent has been accepted for further evaluation and that a bed is available, we will follow the county's transportation agreement.

A health screening was replaced with a medical evaluation, performed by a licensed medical provider, which is documented separately in the respondent's medical record.

Thank you for your assistance in providing care for this patient. If questions arise concerning this matter, please feel free to contact us at (336) 713-5195.

Sincerely,

_____

Atrium Health Wake Forest Baptist

AHWFB INTERNAL USE ONLY:
☐ FAXED TO MAGISTRATE *(336) 779-6701*
☐ CONFIRMED RECEIPT OF FAX *(336) 917-7691*
DATE: _____
TIME: _____ INITIAL: _____