STATE OF NEW MEXICO
COUNTY OF DONA ANA
THIRD JUDICIAL DISTRICT

Cause No.
Judge

IN RE

PETITION FOR EMERGENCY EVALUATION AND TRANSPORT

COMES NOW Petitioner _____ to request that this Court order an Emergency Evaluation of the identified Individual. As grounds for the Petition, Petitioner states as follows:

1. On date , Petitioner observed behavior in the identified Individual that led the Petitioner to conclude that, as a result of a mental disorder, the Individual presents a likelihood of serious harm to him/her self or to others.

2. The ground(s) for Petitioner's belief that the Individual has a mental disorder is (are):

_____

_____

_____

3. Petitioner observed the following behavior in the identified Individual, that resulted in the belief that the Individual presents a likelihood of serious harm to him/her self or others (*include date(s) when the behavior was observed, circumstance(s) of such observation, and nature of the harm*): _____

_____

_____

_____

4. Attached to this Petition is Relevant Demographic Information regarding the Individual which includes the names and phone numbers of others who did or have witnesses the behaviors which form the basis of this Petition.

5. Based upon this Information and Petitioner's observation, Petitioner has reasonable grounds to conclude that the Individual requires immediate detention for the purposes of evaluation and/or treatment.

6. Petitioner respectfully requests that this Court issue an Order for an Emergency Evaluation of the Individual and Order for Transport of the Individual to the closest Evaluation Facility.

7. Petitioner having been first duly sworn upon oath states that Petitioner has read the foregoing Petition and Information contained in and attached hereto, knows and understands the contents therein, and states that the same are true and correct to the best of Petitioner's knowledge and belief.

_____
PETITIONER, TITLE
ADDRESS
PHONE
FAX

SUBSCRIBED AND SWORN to before me by _____ on this the ____ day of _____, 201 .

_____
NOTARY

My Commission Expires:

_____

DEMOGRAPHIC INFORMATION

1. **FULL NAME OF INDIVIDUAL TO BE EVALUATED:** _____

   DATE OF BIRTH ___/___/___ SEX _____ RACE _____

   WEIGHT _____ HEIGHT _____ HAIR COLOR _____ EYE COLOR _____

2. **INDIVIDUAL'S LAST KNOW ADDRESS:**

   _____

   TELEPHONE NUMBER: _____

3. **WHERE IS INDIVIDUAL NOW?** (Provide address if known)

   _____

4. **INDIVIDUAL IS:**

   A. A resident of _____ County, _____ State

   B. Currently present in _____ County, _____ State.

5. **PLACE OF BIRTH:** (State or Country)

   _____

6. **DO YOU BELIEVE THE INDIVIDUAL IS:**

   A. Addicted to drugs, alcohol, and/or other substances? ☐ Yes ☐ No

   B. Has a Mental Disorder? ☐ Yes ☐ No

7. **DO YOU BELIEVE THE INDIVIDUAL, BECAUSE OF THE MENTAL DISORDER PRESENTS A SERIOUS HARM TO:**

   A. Him/Her Self? ☐ Yes ☐ No

   B. Others? ☐ Yes ☐ No

8. **IS THE INDIVIDUAL A SUICIDE RISK?** ☐ Yes ☐ No ☐ Unknown

If Yes, Explain: _____

_____

9. **IS THE INDIVIDUAL VIOLENT?** ☐ Yes ☐ No ☐ Unknown

If Yes, Explain: _____

_____

10. **IS THE INDIVIDUAL IN POSSESSION OF WEAPONS?** ☐ Yes ☐ No ☐ Unknown

If Yes, Identify Weapons and location of Weapons: _____

_____

11. **WITNESSES TO THE BEHAVIOR(S) FOR WHICH THIS EVALUATION HAS BEEN REQUESTED:**

NAME OF WITNESS	TELEPHONE	ADDRESS	RELATIONSHIP

12. **HAS THE INDIVIDUAL BEEN UNDER THE RECENT CARE OF A MENTAL HEALTH PROVIDER?**

☐ Yes ☐ No

If Yes, List the Name, Address, and Phone Number of the Provider(s):

_____

_____

13. **HAS THE INDIVIDUAL BEEN HOSPITALIZED AT A MENTAL HEALTH HOSPITAL OR BEHAVIOR HEALTH UNIT OF A HOSPITAL?** ☐ Yes ☐ No

If Yes, List the Name of the Hospital/Unit and Date(s) of Hospitalization:

_____

_____

14. **HAS OR IS THE INDIVIDUAL TAKING ANY MEDICATIONS?** ☐ Yes ☐ No

If Yes, List the Name(s) of the Medication(s), Dosage(s), and Route(s):

_____

_____

15. **HAS THE INDIVIDUAL EVER BEEN DIAGNOSED WITH MENTAL RETARDATION?**

☐ Yes ☐ No

If Yes, When was the Diagnosis Made and Who Made the Diagnosis:

_____

_____

16. **HAS THE INDIVIDUAL EVER BEEN INVOLUNTARILY COMMITTED TO THE NEW MEXICO BEHAVIORAL HEALTH INSTITUTE OR SIMILARLY-SITUATED LONG-TERM MENTAL HEALTH TREATMENT FACILITY?** ☐ Yes ☐ No

If Yes, Name of Facility (ies) and Date (s) of Commitment:

_____

_____

17. **HAS THE INDIVIDUAL EVER BEEN DETERMINED TO LACK CAPACITY?** ☐ Yes ☐ No

If Yes, When: _____

18. **DOES THE INDIVIDUAL HAVE A TREATMENT GUARDIAN?** ☐ Yes ☐ No

If Yes, Provide the Name, Address and Phone Number: _____

_____

19. **LIST THE NAME(S) AND ADDRESS(ES) FOR THE FOLLOWING:**

Spouse: _____

Parent(s) or Guardian: _____

Adult Children: _____

Brother(s)/Sister(s): _____

Person(s) with Whom the Individual Resides: _____