APPLICATION FOR EMERGENCY ADMISSION FOR EVALUATION
(Pursuant to A.R.S. § 36-524)

STATE OF ARIZONA)
)
COUNTY OF MARICOPA)

MR/MS
WAS DETAINED AT URGENT PSYCHIATRIC CARE CENTRAL
DATE: _____ **TIME:** _____
PROVIDER: _____
TITLE:
SIGNATURE: _____

The undersigned applicant, being first duly sworn/affirmed, hereby requests that:

ConnectionsAZ,Inc. **- UPC**

(Evaluation Agency)

admit the person named herein for evaluation.

1. The undersigned applicant alleges that there is now in the County a person whose name and address are:

_____ _____
(Name) (Address)

and that she/he believes that the person has a mental disorder and as a result of said mental disorder, is: ☐ a danger to self; ☐ a danger to others;

and that during the time necessary to complete pre-petition screening under A.R.S. §§ 36-520 AND 36-521, the person is likely without immediate hospitalization to suffer serious physical harm or serious illness or is likely to inflict serious physical harm upon another person.

The conclusion that the person has mental disorder is based on the following facts:

_____

_____

_____

_____

The specific nature of the danger posed by this person is:_____

_____

_____

_____

A summary of the observations upon which this statement is as follows: _____

_____

_____

_____

_____

_____

_____

PERSONAL DATA OF PROPOSED PATIENT:

Age_____Date of Birth_____ Sex_____Race_____

Weight_____Height_____ Hair Color_____ Eye Color_____

Marital Status_____Number of Children_____

Social Security Number_____ Religion_____

Distinguishing Marks_____

Occupation_____

Present Location_____

Dates and Places of Previous Hospitalization_____

_____

How Long in Arizona_____ State Last From

_____ _____

Veteran_____ C-No. Education

NAME, ADDRESS AND TELEPHONE NUMBER OF:

1) Guardian_____

2) Spouse_____

3) Next of Kin_____

4) Significant Other Persons_____

_____ _____
(Date) (Signature of Applicant)

Printed or Typed name of Applicant_____

Relationship to Proposed Patient_____

Applicant's Address_____

Applicant's Telephone_____

SUBSCRIBED AND SWORN to before me this _____ day of _____, 20_____.

_____
Notary Public

My Commission Expires:

_____

MH-104 (Form B)

WITNESS INFORMATION FORM

PROPOSED PATIENT: _____

WITNESSES DATA:

1. **NAME:** _____ **AGENCY:** _____ **EMAIL** _____

ADDRESS_____

CITY_____**ST**_____**ZIP CODE**_____

HOME NO.: _____**WORK NO.:** _____**CELL NO.:** _____**FAX NO.** _____

RELATIONSHIP TO PROPOSED PATIENT _____
IF WORKING FOR AN AGENCY,
SUPERVISOR'S NAME AND PHONE NO._____

ANTICIPATED TESTIMONY: _____

RE: _____**DTS** _____**DTO** _____**PAD** _____**GD**

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2. **NAME:** _____ **AGENCY:** _____ **EMAIL** _____

ADDRESS_____

CITY_____**ST**_____**ZIP CODE**_____

HOME NO.: _____**WORK NO.:** _____**CELL NO.:** _____**FAX NO.** _____

RELATIONSHIP TO PROPOSED PATIENT _____
IF WORKING FOR AN AGENCY,
SUPERVISOR'S NAME AND PHONE NO._____

ANTICIPATED TESTIMONY: _____

RE: _____**DTS** _____**DTO** _____**PAD** _____**GD**

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3. **NAME:** _____ **AGENCY:** _____ **EMAIL** _____

ADDRESS_____

CITY_____**ST**_____**ZIP CODE**_____

HOME NO.: _____**WORK NO.:** _____**CELL NO.:** _____**FAX NO.** _____

RELATIONSHIP TO PROPOSED PATIENT _____
IF WORKING FOR AN AGENCY,
SUPERVISOR'S NAME AND PHONE NO._____

ANTICIPATED TESTIMONY: _____

RE: _____DTS _____DTO _____PAD _____GD