Transfer Evaluation
(To a State Mental Health Treatment Facility)

I, _____ ☐ concur ☐ do not concur
Full Name of Mental Health Center/Clinic Director or Chief Clinical Officer

that _____ , residing at _____
Full Name of Person Name and Address of Receiving Facility

meets statutory criteria for ☐ voluntary or ☐ involuntary admission to a state mental health treatment facility.
I find that less restrictive community based treatment alternatives have been considered for this person and were determined to be (Check one): ☐ inappropriate ☐ unavailable ☐ appropriate and available.

If placement at a State Mental Health Treatment Facility is recommended, specify the reason for the recommendation:

_____

_____

_____

If it is determined that the person does not meet criteria for admission to a state mental health treatment facility, and consequently a diversion to a less restrictive voluntary community-based service is appropriate, specify the recommended facility and type of service:

_____

_____

_____

_____ _____ _____ _____ am pm
Signature of Evaluator Printed Name and Title of Evaluator Date Time of Evaluation

_____ _____ _____ am pm
Original Signature of Date Time
☐ Executive Director or ☐ Chief Clinical Officer

_____ (_____)_____
Name and Address of Community Mental Health Center or Clinic Telephone Number

This form is to be completed by a designated staff member employed by a Community Mental Health Center or Clinic whenever a person is being considered for admission to a state mental health treatment facility either on a voluntary or involuntary basis. In the case of potential involuntary admission, the original copy of this form shall be provided for the Court's consideration prior to the hearing on the petition for involuntary placement. The evaluator or another knowledgeable person from the center or clinic shall be present at the court hearing to provide testimony as desired by the court.

cc: Check when applicable and initial/date/time when copy provided:

Individual	Date Copy Provided	Time Copy Provided	Initials of Who Provided Copy
☐ Circuit Court		am pm	
☐ District DCF Mental Health Office		am pm	

By Authority of s. 394.455(29), 394.461, Florida Statutes
CF-MH 3089, Feb 05 (obsoletes previous editions) (Mandatory Form) **BAKER ACT**