

## **Sample Forms of PRCS Release Package**

The following forms from the Release Package are attached below:

1. Package Cover Sheet
2. Release of Information form
3. Mental Health form 7390 – AIMS
4. Mental Health form 7447 – Suicide Risk Evaluation
5. Mental Health form 7388 – Mental Health Treatment Plan
6. Mental Health form 7389 – Brief Mental Health Evaluation
7. Mental Health Work Sheet

**Post Release Community Supervision (PRCS)  
CDCR Package Cover Sheet**

**To:**

**Name:** \_\_\_\_\_

**Organization:** \_\_\_\_\_

The below offender is being released on PRCS and has signed a consent to release information. The enclosed documents are being sent to assist in the treatment of the offender.

**Offender:**

**Name:** \_\_\_\_\_

**CDCR#:** \_\_\_\_\_

**Institution Mental Health PRCS Liaison:** \_\_\_\_\_

**Phone Number w/Extension:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Fax Number:** \_\_\_\_\_

**Forms Included in Release Planning Package: (Please Check)**

- 7390 – Abnormal Involuntary Movement Scale (AIMS) for Tardive Dyskinesia
- 7447 – Suicide Risk Evaluation
- 7388 – Mental Health Treatment Plan
- 7389 – Brief Mental Health Evaluation
- Mental Health Work Sheet
- Signed Release of Information

**Comments:**

# AUTHORIZATION FOR RELEASE OF INFORMATION

<b>YOUR INFORMATION</b>			
Last Name:	First Name:	Middle Name:	Date of Birth:
Address:	City/State/Zip:		CDC/YA Number:

<b>Person/Organization Providing the Information</b>	<b>Person/Organization to Receive the Information</b>
Name: _____	Name: _____
Address: _____	Address: _____
City/State/Zip: _____	City/State/Zip: _____
Phone #: (____) _____	Phone #: (____) _____
Fax Number: (____) _____	Fax Number: (____) _____
[45 C.F.R. § 164.508(c)(1) (iii) & Civ. Code § 56.11(e), (f)]	

<b>Description of the Information to be Released</b> (Provide a detailed description of the specific information to be released) [45 C.F.R. § 164.508(c)(1)(i) & Civ. Code §§ 56.11(d) & (g)]		
<input type="checkbox"/> Medical	<input type="checkbox"/> Mental Health	<input type="checkbox"/> Genetic Testing
<input type="checkbox"/> Dental	<input type="checkbox"/> Substance Abuse/Alcohol	<input type="checkbox"/> Communicable Disease
<input type="checkbox"/> HIV	<input type="checkbox"/> Psychotherapy Notes	<input type="checkbox"/> Other (Please Specify)
_____		
For the following period of time: From _____ (date) to _____ (date)		

<b>Description of Each Purpose for the Use or Release of the Information</b> (Indicate how the information will be used) [45 C.F.R. § 164.508(c)(1)(iv)]		
<input type="checkbox"/> Health Care	<input type="checkbox"/> Personal Use	<input type="checkbox"/> Legal
<input type="checkbox"/> Other (please specify) _____		

**Will the health care provider receive money for the release of this information?**

[45 C.F.R. § 164.524 (c) (4) (i), (ii)]

Reasonable fees may be charged to cover the cost of copying and postage.

This authorization for release of the above information to the above-named persons/organizations will expire on: \_\_\_\_\_ (date). [45 C.F.R. § 164.508(c)(1)(v) & Civ. Code § 56.11(h)]

**I understand:**

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed. I understand that this authorization is voluntary. [45 C.F.R. § 164.508(c)(2)(i)]
- I have the right to revoke this authorization by sending a signed notice stopping this authorization to the health Records department at my current institution. The authorization will stop further release of my health information on the date my valid revocation request is received in the Health Records department. [45 C.F.R. § 164.508(c)(2)(i) & Civ. Code § 56.11(h)]
- I am signing this authorization voluntarily and that my treatment will not be affected if I do not sign this authorization. [45 C.F.R. § 164.508(c)(2)(ii)]
- Under California law, the recipient of the protected health information under the authorization is prohibited from re-disclosing the information, except with a written authorization or as specifically required or permitted by law. If the organization or person I have authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. [45 C.F.R. 164.508(c)(2)(ii)]
- I understand I have the right to receive a copy of this authorization. [Civ. Code § 164.508 (c)(4) and Civ. Code § 56.11(i)]

Signature:	CDC/YA Number:	Date:
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[45 C.F.R. § 164.508(c)(1)(vi) & Civ. Code § 56.11(c)(1)]

Representative:	Relationship:	Date:
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[45 C.F.R. § 164.508(g)(1) & Civ. Code § 56.11(c)(2)]

**Mental Health AIMS Examination for Tardive Dyskinesia**

CDCR 7390 (Rev. 07/11)

**Antipsychotic Medication History**

Current:

Past:

Tardive Dyskinesia History:

**Abnormal Involuntary Movement Scale Examination**

Code:            0 = None            1 = Minimal, Extreme Normal            2 = Mild            3 = Moderate            4 = Sever, Incapacitating

Date:

<b>Facial and Oral Movements</b>	Muscles of facial expression: e.g., forehead eyebrow area, cheeks, frowning, blinking, smiling, grimacing.						
	Lips and peri-oral area: e.g., puckering, pouting, smacking.						
	Jaw: e.g. biting, clenching, chewing, mouth opening, lateral movement.						
	Tongue: Rate movement increases in and out of mouth, NOT inability to sustain movement, or vermicular.						
<b>Extremity Movements</b>	Arm: Charatic, rapid, purposeless, irregular, spontaneous, athetoid, repetitive, serpentine, NOT tremor.						
	Leg: Lateral knee movement, foot tapping, heel dropping, foot squirming, inversion and eversion foot.						
<b>Trunk Movement</b>	Neck, shoulders, hips: Rocking, twisting, squirming, pelvic gyrations.						
<b>Total Score</b> (Scores of five or above need validation by a second opinion and assessment by the IDTT.)							

Clinician's Name and Title	Signature	Date
<b>Institution:</b>	<b>Inmate Bed Number:</b>	<b>Level of Care:</b>

<p>1. <u>Disability Code:</u></p> <p><input type="checkbox"/> TABE score ≤ 4.0    <input type="checkbox"/> DPH   <input type="checkbox"/> DPV   <input type="checkbox"/> LD    <input type="checkbox"/> DPS   <input type="checkbox"/> DNH    <input type="checkbox"/> DNS   <input type="checkbox"/> DDP    <input type="checkbox"/> NOT APPLICABLE</p> <p>2. <u>Accommodation:</u></p> <p><input type="checkbox"/> Additional time    <input type="checkbox"/> Equipment   <input type="checkbox"/> SLI    <input type="checkbox"/> Louder   <input type="checkbox"/> Slower    <input type="checkbox"/> Basic   <input type="checkbox"/> Transcribe    <input type="checkbox"/> Other*</p> <p>3. <u>Effective Communication:</u></p> <p><input type="checkbox"/> P/I asked questions    <input type="checkbox"/> P/I summed information    <b>Please check one:</b>  <input type="checkbox"/> Not reached*   <input type="checkbox"/> Reached    *See chrono/notes</p> <p>4. <u>Comments:</u></p>	Inmate's Name (Last, First, MI), CDC Number, DOB
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**Mental Health AIMS Examination for Tardive Dyskinesia**

CDCR 7390 (Rev. 07/11)

**Instructions:**

This form is to be used to assess involuntary movement disorders for inmate-patients who are receiving antipsychotic medication. It may be completed by any clinician or nursing staff who have been trained in the use of this form.

The AIMS form is to be completed at initiation of antipsychotic medication treatment and every six months thereafter. Complete when antipsychotics are discontinued and two months later. Assessment is done with inmate-patient at rest, extending tongue or limbs or performing activities such as finger tapping, standing, or walking. Check for rigidity. Do not rate the tremor. Follow examination steps described below.

Either before or after completing the examination, observe the inmate-patient unobtrusively, at rest (i.e. waiting area). The inmate-patient should use a hard, firm chair without arms.

1. Document the AIMS Test on an Interdisciplinary Progress Note, CDCR 7230-MH, and make any comments there.
2. Stamp the bottom right corner of the form with addressograph or print the inmate's name, CDC number, and date of birth.
3. Complete the Effective Communication label at the bottom of the page. (This is required for all Armstrong inmate-patients only.) If no disability codes are required, check Not Applicable. No further action is required.
4. Print name and title, sign, and date form.
5. File in the UHR.

**Antipsychotic Medication History**

Complete the sections for current medication history, past medication history, and Tardive history.

**Abnormal Involuntary Movement Scale Examination**

Complete the examination steps as below:

1. Ask the inmate-patient to remove their shoes and socks.
2. Ask if there is anything in their mouth (i.e. gum, candy, etc.) and if there is, to remove it.
3. Ask the inmate-patient about the current condition of their teeth. Do they currently wear dentures? Are the teeth or dentures causing any problems?
4. Ask whether the inmate-patient notices any movement in their mouth, face, hands, feet, or torso. If yes, ask to describe the extent the movements currently bother them or interfere with activities.
5. Have the inmate sit in the chair with hands on knees, legs slightly apart, and feet flat on the floor. Look at the entire movements while in this position.
6. Have the inmate-patient sit in the chair with hands hanging unsupported. If male, between legs, and if female with dress, hang over knees. Observe hands and other body parts.
7. Have the inmate-patient open their mouth. Observe tongue at rest within the mouth. Repeat this procedure.
8. Have the inmate-patient protrude their tongue. Observe for abnormalities of tongue movement. Repeat this procedure.
9. Have inmate-patient tap their thumb with each finger, as rapidly as possible for 10 to 15 seconds; separately with the right hand, then with the left hand. Observe facial and leg movements.
10. Extend the inmate-patient's left and right arms, one at a time. Note any rigidity.
11. Have the inmate-patient stand. Observe in profile. Observe all body areas, including hips.
12. Have the inmate-patient extend both arms, outstretched in front with palms down. Observe trunk, legs, and mouth.
13. Have the inmate-patient walk a few paces, turn and walk back to the chair. Observe hands and gait. Repeat this step.
14. Total the scores. If the score is five or above, obtain a second opinion. The IDTT should review the case.

Date of Assessment:		Time:	Institution:	Reason for assessment:
Age:	Ethnicity:	Current LOC: <input type="checkbox"/> None <input type="checkbox"/> CCCMS <input type="checkbox"/> EOP <input type="checkbox"/> MHCB		
Sources of Information (Mark all that apply): <input type="checkbox"/> C/O or Staff Interview(s) <input type="checkbox"/> I/P Interview <input type="checkbox"/> UHR <input type="checkbox"/> C-File <input type="checkbox"/> Other:				

## PART 1: DATA COLLECTION

CHRONIC RISK FACTORS (Historic and Demographic)		ACUTE RISK FACTORS (Within 3 months)					
Present? Yes No		Present? Yes No					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Family history of suicide(s)	<input type="checkbox"/>	<input type="checkbox"/>	Suicidal ideation (including passive ideation)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	History of emotional, physical, or sexual abuse	<input type="checkbox"/>	<input type="checkbox"/>	Recent serious suicide attempt
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	History of major depressive disorder	<input type="checkbox"/>	<input type="checkbox"/>	Current/recent depressive episode
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	History of psychotic disorder	<input type="checkbox"/>	<input type="checkbox"/>	Current/recent psychotic symptoms
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic pain problem	<input type="checkbox"/>	<input type="checkbox"/>	Current/recent anxiety or panic symptoms
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic medical illness	<input type="checkbox"/>	<input type="checkbox"/>	Current/recent substance abuse/intoxication
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	History of substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	Hopelessness/helplessness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	History of violence (including index crime)	<input type="checkbox"/>	<input type="checkbox"/>	Increasing interpersonal isolation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	History of poor impulse control	<input type="checkbox"/>	<input type="checkbox"/>	Agitated or angry
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Perception of loss of social support	<input type="checkbox"/>	<input type="checkbox"/>	Current/recent violent behavior
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	First prison term	<input type="checkbox"/>	<input type="checkbox"/>	Recent serious medical diagnosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Long or life sentence	<input type="checkbox"/>	<input type="checkbox"/>	Disturbance of mood/lability
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sex offender	<input type="checkbox"/>	<input type="checkbox"/>	Recent trauma (including sexual trauma)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Caucasian/White ethnicity	<input type="checkbox"/>	<input type="checkbox"/>	Recent bad news, loss or anniversary date
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Older than 35 years of age.	<input type="checkbox"/>	<input type="checkbox"/>	Early in prison term
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Male	<input type="checkbox"/>	<input type="checkbox"/>	Recent change in housing (e.g., Ad Seg)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	History of suicide attempts.	<input type="checkbox"/>	<input type="checkbox"/>	Safety concerns (e.g., gang dropout)
Note details (number, lethality, method, age, etc.):				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Single cell placement
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recent negative staff interactions
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Evidence of medication hoarding/cheeking
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recent disciplinary ("115")

## PROTECTIVE FACTORS

Present? Yes No		Present? Yes No					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Family Support (e.g. visiting, correspondence)	<input type="checkbox"/>	<input type="checkbox"/>	Children at home
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Religious/spiritual/cultural beliefs	<input type="checkbox"/>	<input type="checkbox"/>	Spousal support
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Interpersonal social support	<input type="checkbox"/>	<input type="checkbox"/>	Insight into problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Future orientation/plans for future	<input type="checkbox"/>	<input type="checkbox"/>	Job or school assignment
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exercises regularly	<input type="checkbox"/>	<input type="checkbox"/>	Active and motivated in psych treatment
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Positive coping skills & conflict resolution skills	<input type="checkbox"/>	<input type="checkbox"/>	Sense of optimism; self-efficacy

<b>Does the inmate report a plan to kill him/herself?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the inmate report a desire to die?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
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1. Disability Code: <input type="checkbox"/> TABE score ≤ 4.0 <input type="checkbox"/> DPH <input type="checkbox"/> DPV <input type="checkbox"/> LD <input type="checkbox"/> DPS <input type="checkbox"/> DNH <input type="checkbox"/> DNS <input type="checkbox"/> DDP <input type="checkbox"/> Not Applicable 2. Accommodation: <input type="checkbox"/> Additional time <input type="checkbox"/> Equipment <input type="checkbox"/> SLI <input type="checkbox"/> Louder <input type="checkbox"/> Slower <input type="checkbox"/> Basic <input type="checkbox"/> Transcribe <input type="checkbox"/> Other* 3. Effective Communication: <input type="checkbox"/> P/I asked questions <input type="checkbox"/> P/I summed information <b>Please check one:</b> <input type="checkbox"/> Not reached* <input type="checkbox"/> Reached *See chrono/notes 4. Comments:	Inmate's Name (Last, First, MI), CDC Number, DOB
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**SUICIDE RISK EVALUATION**

CDCR 7447 (Rev. 07/11)

**Instructions**

The Suicide Risk Evaluation (SRE) form must be used whenever an inmate presents with signs or symptoms of an elevated risk of suicide. Suicide risk may be indicated by verbalizations of suicidal thoughts, suicide attempts, a significant history of past suicidal ideas or behaviors, and/or other information. A SRE shall be completed:

- Every time an inmate has an initial face-to-face evaluation for suicidal ideation, threats, or attempts.
- By the referring clinician prior to placement of an inmate into an Outpatient Housing Unit (OHU) for continued suicide risk evaluation or into a Mental Health Crisis Bed (MHCB) for suicidal ideation, threats, or attempt.
- After hours, on weekends and holidays, on-call clinicians shall conduct a face-to-face evaluation of suicide risk prior to releasing an inmate to any housing without suicide watch or precaution.
- By the clinician providing coverage after hours, on weekends and holidays, when the referring clinician has not completed an SRE, by the next day (for those inmate-patients placed into an OHU or MHCB).
- By the associated Interdisciplinary Treatment Team (IDTT) and/or clinician for all inmate's placed into an OHU, for mental health reasons, or MHCB, for any reason, upon decision to release or discharge.
- Subsequent to release from an OHU placement that was for the purpose of continued suicide risk evaluation, or discharge from a MHCB placement for the reason of suicidal ideation, threats, or attempts, at a minimum of every ninety (90) days for a twelve month period.
- Within seventy-two (72) hours of return from a Department of Mental Health (DMH) facility, or within twenty-four (24) hours if clinically indicated based on new arrival screening.
- Any time the medical and mental health screening of a new arrival to an institution indicates a current or significant history, over the past year, of suicide risk factors, ideation, threats, or attempts.
- Pursuant to Department Operating Manual, Article 41, Prison Rape Elimination Act Policy, for victims of sexual assault, within four hours after the required sexual assault forensic examination.

The SRE must be completed by a trained clinician any time there is a concern about elevated suicide risk. (When an inmate expresses chronic suicidal ideation without intent or plan, the clinician may document that no change in suicide risk has occurred since completion of the prior SRE, instead of completing a full SRE.) The listing of acute and chronic risk and protective factors is not an actuarial process.

When completed, both parts (pages 1 and 2) must be filed in the Unit Health Record and data entered into the Mental Health Tracking System.

A thorough and adequate SRE includes: 1) Identification of both Chronic and Acute Risk Factors; 2) Identification of recent precipitating stressors; 3) Identification of Protective Factors; 4) Inquiry regarding intent, planning, ideation, behavior; 5) Judgment of Risk Level and its justification; and 6) Treatment Plan that includes methods to reduce acute risk and enhance protective factors.

**Specific Instructions:****Part 1: Data Collection**

1. Complete each section of Part 1 – include background information and Complete the Effective Communication label at the bottom of the page. (This is required for all Armstrong inmate-patients only.). If no disability codes are required, check Not Applicable. No further action is required.
2. A thorough evaluation of suicide risk requires information about the presence or absence of all risk factors in Part 1. If information is not available –indicate this on the form.
3. At least two sources of information must be used for completing the evaluation, and using all four sources indicated is preferable.
4. Chronic risk factors are unlikely to change on subsequent SRE forms, unless new information is received. If changes are noted these should be indicated.
5. Acute risk factors may change and subsequent SRE forms will reflect these changes.
6. Protective Factors are balanced against Risk Factors.
7. Do not rely only on inmate self-report – use multiple sources of information when possible.

## PART 2: ADDITIONAL INFO, ESTIMATE OF RISK, & TREATMENT PLAN

ADDITIONAL DETAILS (INCLUDING MENTAL STATUS EXAM):

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### ESTIMATE OF RISK

*CHRONIC RISK*

Low

Moderate

High

*ACUTE RISK*

Low

Moderate

High

JUSTIFICATION OF RISK LEVEL:

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TREATMENT PLAN:

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Clinician Name/Title (Print): \_\_\_\_\_ Date: \_\_\_\_\_

Clinician Signature: \_\_\_\_\_

**SUICIDE RISK EVALUATION**  
**CDCR 7447 (Rev. 07/11)**

Confidential Inmate-Patient Information

Inmate's Name (Last, First, MI), CDC Number, DOB

**SUICIDE RISK EVALUATION**

CDCR 7447 (Rev. 07/11)

**Instructions****Part 2: Additional Information, Risk Level, Justification, and Treatment Plan**

1. Supply additional information about the inmate including a mental status exam.
2. The judgment of risk (Low, Medium, High) is based on the factors indicated, but is a matter of clinical judgment.
3. The Justification of Risk should follow directly from the data collected (or conversely: the data collected should lead directly to the justification of assessed risk).
4. While it is true that risk elevates as risk factors accumulate, the simple summation of the number of checked boxes is not to be interpreted as an accurate reflection of the degree of suicide risk. Additionally, risk factors can act synergistically (“the whole is greater than the sum of its parts”) and the quality of the interaction between risk factors is not easily captured by a number.
5. Inmates with plans for suicide are at higher risk than those without plans for suicide (although those without plans may still attempt suicide).
6. An accumulation of Acute Risk factors can quickly elevate overall risk.
7. Acute Risk factors can quickly overwhelm Protective Factors.
8. Inmate-patients with two or more documented serious suicide attempts should always be considered at higher risk than those with no history or only one attempt.
9. The Treatment Plan should logically follow from the evaluation (reduction of acute risk, enhancement of protective factors).
10. Consider adding recommendations for short- and medium-term treatment.
11. The clinician completing the evaluation must sign the form and print name legibly.
12. Indicate the date form is completed.
13. Stamp with addressograph, or print inmate name, CDC number, and date of birth.

**Treatment Planning**

## General Issues

- Plans should be based on data collected and the risk level.
- Plans should target changeable (i.e. acute) risk factors and, if possible, reinforcement of protective factors.
- Plans should be collaborations between inmates and clinicians.
- Plans should reflect a problem-solving approach.

## Specific Issues

- Use the inmate’s language in constructing a plan with them.
- Discuss with the inmate when the plan will be used (e.g., ask: How will you know when to use the plan? What will be happening? What do you experience when you start to have suicidal thoughts?)
- What strategies can the inmate use to reduce or eliminate the suicidal thoughts?
- What environmental changes (if any) could be considered?
- What clinical interventions (e.g., increased frequency of contact; group participation; psychiatric consult; etc.) should be considered?
- Is it possible to increase social or family support?
- If in Administrative Segregation, what interventions could decrease isolation and distress?
- What collaborative efforts with custody could decrease distress and suicidal thinking?
- Include short- and medium-term interventions.

I. Inmate Information			
Custody Level:	EPRD:	Current LOC:	Current Housing:
Institution:	Arrival Date: From:	IDTT:	Next IDTT:
<input type="checkbox"/> Initial	<input type="checkbox"/> Bi Weekly MHCB Review	<input type="checkbox"/> Quarterly Review	<input type="checkbox"/> Annual Review
Update:	Update:	Update:	
1. <u>Disability Code:</u> <input type="checkbox"/> TABE score ≤ 4.0 <input type="checkbox"/> DPH <input type="checkbox"/> DPV <input type="checkbox"/> LD <input type="checkbox"/> DPS <input type="checkbox"/> DNH <input type="checkbox"/> DNS <input type="checkbox"/> DDP <input type="checkbox"/> Not Applicable 4. <u>Comments:</u>	2. <u>Accommodation:</u> <input type="checkbox"/> Additional time <input type="checkbox"/> Equipment <input type="checkbox"/> SLI <input type="checkbox"/> Louder <input type="checkbox"/> Slower <input type="checkbox"/> Basic <input type="checkbox"/> Transcribe <input type="checkbox"/> Other* 3. <u>Effective Communication:</u> <input type="checkbox"/> P/I asked questions <input type="checkbox"/> P/I summed information Please check one: <input type="checkbox"/> Not reached* <input type="checkbox"/> Reached *See chrono/notes	1. <u>Disability Code:</u> <input type="checkbox"/> TABE score ≤ 4.0 <input type="checkbox"/> DPH <input type="checkbox"/> DPV <input type="checkbox"/> LD <input type="checkbox"/> DPS <input type="checkbox"/> DNH <input type="checkbox"/> DNS <input type="checkbox"/> DDP <input type="checkbox"/> Not Applicable 4. <u>Comments:</u>	2. <u>Accommodation:</u> <input type="checkbox"/> Additional time <input type="checkbox"/> Equipment <input type="checkbox"/> SLI <input type="checkbox"/> Louder <input type="checkbox"/> Slower <input type="checkbox"/> Basic <input type="checkbox"/> Transcribe <input type="checkbox"/> Other* 3. <u>Effective Communication:</u> <input type="checkbox"/> P/I asked questions <input type="checkbox"/> P/I summed information Please check one: <input type="checkbox"/> Not reached* <input type="checkbox"/> Reached *See chrono/notes
II. Risk Factors/Behavioral Alerts			
History of: <input type="checkbox"/> Self Injurious Behavior <input type="checkbox"/> Suicide Attempts <input type="checkbox"/> Assaultive Behavior <input type="checkbox"/> Sexual Misconduct			
<input type="checkbox"/> History or Current Suicidal Ideation <input type="checkbox"/> Meds Alert <input type="checkbox"/> Keyhea			
For Additional Information See Form: Describe:		Dated:	Date of Last SRE:
III. Clinical Summary			
IV. Psychotropic Medications			
Medication and dosage:	Target Symptom:	Goal:	Progress/Date:
<b>Labs Ordered:</b> <input type="checkbox"/> None <input type="checkbox"/> Chem 7 <input type="checkbox"/> CMP/Chem 20 <input type="checkbox"/> Chem 11 <input type="checkbox"/> Chem 10 Lipid <input type="checkbox"/> Fasting Lipids <input type="checkbox"/> Fasting blood Gluc/A1C <input type="checkbox"/> Bun/Cr <input type="checkbox"/> LFT <input type="checkbox"/> CBC w/ diff. <input type="checkbox"/> RPR <input type="checkbox"/> TSH <input type="checkbox"/> Thyroid Panel <input type="checkbox"/> Amylase <input type="checkbox"/> EKG <input type="checkbox"/> Teg <input type="checkbox"/> Lithium Level <input type="checkbox"/> Valpro <input type="checkbox"/> Prolac			
Referral for Medical Evaluation Requested: <input type="checkbox"/> Yes <input type="checkbox"/> No		Type:	
V. DSM IV Diagnosis			
Axis I			
Axis II			
Axis III			
Axis IV			
Axis V	GAF Equivalent =		
1. <u>Disability Code:</u> <input type="checkbox"/> TABE score ≤ 4.0 <input type="checkbox"/> DPH <input type="checkbox"/> DPV <input type="checkbox"/> LD <input type="checkbox"/> DPS <input type="checkbox"/> DNH <input type="checkbox"/> DNS <input type="checkbox"/> DDP <input type="checkbox"/> NOT APPLICABLE 4. <u>Comments:</u>	2. <u>Accommodation:</u> <input type="checkbox"/> Additional time <input type="checkbox"/> Equipment <input type="checkbox"/> SLI <input type="checkbox"/> Louder <input type="checkbox"/> Slower <input type="checkbox"/> Basic <input type="checkbox"/> Transcribe <input type="checkbox"/> Other*	3. <u>Effective Communication:</u> <input type="checkbox"/> P/I asked questions <input type="checkbox"/> P/I summed information <b>Please check one:</b> <input type="checkbox"/> Not reached* <input type="checkbox"/> Reached *See chrono/notes	Inmate's Name (Last, First, MI), CDC Number, DOB

## Instructions

The Mental Health Treatment Plan shall be used for every inmate in the Mental Health Services Delivery System (MHSDS). The treatment plan should be started by the Clinical Case Manager or Primary Clinician and discussed and completed by the Interdisciplinary Treatment Team (IDTT) within 14 working days after admission for CCCMS inmates; within 14 or 28 calendar days after admission to EOP; and within 24-hours of admission to the MHCB. Refer to MHSDS Program Guide for details. This form should be revised and a new form completed whenever there is a change in the inmate's condition, treatment plan, or level of care. A new Treatment Plan form must be completed at least annually for inmates in the CCCMS and EOP programs.

### General Instructions

1. All items on the form must be filled in.
2. The handwriting must be legible. Print or type if necessary.
1. Complete the Effective Communication label at the bottom of the page. (This is required for all Armstrong inmate-patients only.) If no disability codes are required, check NOT APPLICABLE. No further action is required.
2. Use an addressograph stamp or write the inmate's name, CDC number, and Date of Birth in the bottom right box on each page.

### I. Inmate Information

1. Indicate the inmate's current custody level.
2. Enter the inmates Expected Parole Release Date (EPRD).
3. Enter current Level of Care (LOC), current housing, and current institution.
4. Fill in the Arrival Date at the treatment setting and indicate from which institution/level of care.
5. Enter today's date and the date of the next required update (one year for routine CCCMS and EOP). The next update may be scheduled at an earlier date according to the inmate's clinical needs or other factors.

### Update:

1. If there are no changes in the inmate's functioning, treatment plan, or level of care, enter the date reviewed and initials of team leader at the top of the page.
2. Complete the Effective Communication label under the update section. (This is required for all Armstrong inmate-patients only.) If no disability codes are required, check NONE. No further action is required.
3. A detailed progress note is required when the CDCR 7388 is reviewed but not changed. List the members who attended the meeting in the progress notes.
4. No more than three updates may be used on a Mental Health Treatment Plan. After three updates, a new treatment plan shall be created.

### II. Risk Factors/Behavioral Alerts

1. Check box(s) indicating current risk factors and behavioral alerts. If additional information was used from another source, indicate from which source (i.e. form name), date of source, and briefly describe.
2. Enter the date of the last SRE.

### III. Clinical Summary

Write a brief clinical summary describing key factors in the inmate's clinical condition and need for treatment.

### IV. Psychotropic Medications

1. Indicate the name of the medication and dosage, target symptom, and goal of treatment with that medication (i.e., reduce hallucination, decrease depression), and progress/date.
2. Labs Ordered – This section shall be completed by the psychiatrist at the IDTT. Check appropriate box(es) of labs to be ordered (examples below). If no labs to be ordered, check NONE.
  - a. Chem 11 (Na, K, Cl, CO<sub>2</sub>, Glu, Bun, Cre, Amy, Ast, Alt, Ldh, Ggt, Ca, Mg, Phos, Tp, or Bili)
  - b. Chem 10 Lipid (CHOL, HDL, TRIG, Calc, LDL, or VLDL)
  - c. CBC w/ diff. (inc. ANC)

### V. DSM IV DIAGNOSIS

This shall be the official diagnosis decided by the IDTT. List all DSM diagnoses. Give name and DSM number. For inpatients, also give ICD Code. Reception Center diagnosis may be provisional. Axis IV: Rate each domain of functioning as: no impairment (leave domain blank), Mild = 1, Moderate = 2, Severe = 3. Use results to determine the Global Assessment of Functioning (GAF) using scale in DSM manual.

**VI. Mental Status Examination**

A. Appearance

B. Behavior/Cooperation

C. Orientation  WNL

D. Speech  WNL

E. Affect  WNL

F. Mood  WNL

G. Sleep/Appetite  WNL

H. Cognition:

Fund of Information  WNL

Intellectual Functioning  WNL

Concentration  WNL

Attention  WNL

Memory  WNL

I. Thought Process  WNL

Tangential

Circumstantial

Loose

Laborious/slow

Other:

J. Perception:

Hallucinations  None

K. Thought Process:

Delusions  WNL

Ideas of Reference  WNL

Obsessions  WNL

Magical Thinking  WNL

Other:

L. Insight  WNL

M. Judgment  WNL

**MENTAL HEALTH TREATMENT PLAN  
CDCR 7388 (Rev. 07/11)**

Confidential Inmate-Patient Information

Name (Last, First, MI), CDC Number, DOB

## Instructions

### VI. Mental Status Examination

- A. Appearance - Describe inmate's appearance, including dress, grooming, body type, posture, nutritional status, hair color, and anything unusual.
- B. Behavior/ Cooperation - Describe inmate's general behavior including reaction to interview, eye contact, psychomotor movements, unusual gestures, facial movements, abnormal movements, level of cooperation, estimate of truthfulness, and accuracy of information provided.
- C. Orientation: - Indicate if inmate is oriented in all spheres; describe deficits or check WNL.
- D. Speech - Note if there are any unusual speech patterns, speech disorders (i.e., stuttering), problems of articulation, pressured speech, unusual phrasing and grammar, unusual use of words, neologisms or check WNL.
- E. Affect - Describe emotional expression including range of feelings, appropriateness, intensity, and duration or check WNL.
- F. Mood - Describe quality, stability, reactivity, intensity, and duration. If depressed, explore past history of depressive episodes or check WNL.
- G. Sleep/Appetite - Describe any problems with patient's sleep patterns: hypersomnia, insomnia or check WNL. If insomnia, inquire whether there is a problem falling asleep, staying asleep, or early morning awakening. Ask about nature of dreams. Indicate duration of problem. Describe increased or decreased appetite, weight gain or weight loss, duration of problem. Ask about eating disorders.
- H. Cognition - Describe in detail any abnormal cognitive processes or check WNL. Fund of Information: Indicate whether normal, impoverished, enriched. Intellectual Functioning: In addition to information gained during the course of the interview, indicate results of intellectual screening/testing, TABE test, or school performance if available. Estimate whether intellectual ability lies in below average, average, or above average range.
- I. Thought Processes - Include description of organization, and level of abstraction. Check WNL or tangential, circumstantial, loose, or laborious/slow (check all that apply).
- J. Perception: Hallucinations. Describe any type of perceptual disturbances (i.e., auditory, visual, olfactory); when they started, whether present all the time, and how they are controlled or check WNL.
- K. Thought Process: Delusions. Describe content, meaning, type, (i.e., grandiose, paranoid, guilt), and inmate's reaction or check WNL.
- L. Insight - Describe level of awareness and understanding of symptoms and problems or check WNL.
- M. Judgment - Describe inmate's ability to make socially appropriate decisions, set reasonable goals, cope effectively with problems of daily living, respect the rights of others or check WNL.

<b>VII. Current Treatment Plan</b>		
<b>Problem Description:</b>		
<b>Long-Term Goal(s)</b>	<b>Target Date</b>	<b>Clinical Status Progress/Date</b>
Responsible Person:		
<b>Short-Term Goal(s)</b>	<b>Target Date</b>	<b>Clinical Status Progress/Date</b>
1.		
Treatment Modality: Responsible Person:		
2.		
Treatment Modality: Responsible Person:		
3.		
Treatment Modality: Responsible Person:		
<b>Problem Description:</b>		
<b>Long-Term Goal(s)</b>	<b>Target Date</b>	<b>Clinical Status Progress/Date</b>
Responsible Person:		
<b>Short-Term Goal(s)</b>	<b>Target Date</b>	<b>Clinical Status Progress/Date</b>
1.		
Treatment Modality: Responsible Person:		
2.		
Treatment Modality: Responsible Person:		
3.		
Treatment Modality: Responsible Person:		
<b>MENTAL HEALTH TREATMENT PLAN</b> <b>CDCR 7388 (Rev. 07/11)</b>  Confidential Inmate-Patient Information		Inmate's Name (Last, First, MI), CDC Number, DOB

## **Instructions**

### **VII. Current Treatment Plan**

1. Indicate the problem and describe the problem (i.e., isolating self from others).
2. Indicate the long-term goal for the problem (i.e. participate in full program). Describe the goal of the treatment in measureable, behavioral terms.
3. Indicate the short-term goal for the problem (i.e. attend yard two times per week and group once a week). At a minimum, one short-term goal shall be included for each long-term goal. Describe the goal of the treatment in measureable, behavioral terms.
4. Describe the type of intervention or treatment modality (i.e., individual or group therapy, anger management) and person responsible.
5. If this is an updated treatment plan, briefly describe the inmate's clinical progress toward the goal and date.
6. Include interventions for lack of inmate-patient participation in treatment.

**VIII. Inmate-Patient Strengths and Weaknesses**

Inmate-Patient Strengths	Inmate-Patient Weaknesses
1.	1.
2.	2.
3.	3.
4.	4.

**IX. Inmate-Patient Participation in Treatment Planning**

Contributed to goals and plan	<input type="checkbox"/> Yes <input type="checkbox"/> No	Refused to participate	<input type="checkbox"/> Yes <input type="checkbox"/> No
Aware of plan content	<input type="checkbox"/> Yes <input type="checkbox"/> No	Unable to participate	<input type="checkbox"/> Yes <input type="checkbox"/> No
Present at team meeting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Refused to sign	<input type="checkbox"/> Yes <input type="checkbox"/> No

Inmate-Patient's Comments:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Inmate-Patient Signature

**X. Transfer/Discharge Planning**

Transfer/Discharge to:  Non-MHSDS  CCCMS  EOP  MHCB  APP  ICF  Parole

**Will inmate be discharged as medical necessity to lower level of care, document rationale:**  Yes  No

Describe:

\_\_\_\_\_

**XI. Treatment Team Members**

	Member Signature:	Date:	Print Name:
Primary Clinician:	_____	_____	_____
Psychiatrist:	_____	_____	_____
Correctional Counselor:	_____	_____	_____
Other: _____	_____	_____	_____
Other: _____	_____	_____	_____
Other: _____	_____	_____	_____
Other: _____	_____	_____	_____
Other: _____	_____	_____	_____

<p><b>MENTAL HEALTH TREATMENT PLAN</b>  <b>CDCR 7388 (Rev. 07/11)</b></p> <p>Confidential Inmate-Patient Information</p>	<p>Inmate's Name (Last, First, MI), CDC Number, DOB</p>
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## **Instructions**

### **VIII. Inmate-Patient Strengths and Weaknesses**

List strengths and weaknesses for the inmate (i.e. medication compliant, good insight, or poor treatment compliance).

### **IX. Inmate-Patient Participation in Treatment Planning**

1. Based on the inmate's participation, check the appropriate box(es).
2. Allow the inmate to provide comments about the treatment plan.
3. Have the inmate sign the treatment plan.

### **X. Transfer/Discharge Planning**

1. If inmate is being transferred or discharged, check box to indicate level of care.
2. Briefly describe the discharge plan. This section should describe the reasons for the new level of care.

### **XI. Treatment Team Members**

Each member of the team must sign their name, date, and legibly print their name. If included in the "other section" title (i.e. Primary Clinician), sign, date, and print name.

BRIEF MENTAL HEALTH EVALUATION		
Reason for Evaluation: <input type="checkbox"/> Self Referral <input type="checkbox"/> Staff Referral <input type="checkbox"/> Medication Review <input type="checkbox"/> CTC Pre-Admission <input type="checkbox"/> Update		
Current Level of Care: <input type="checkbox"/> None <input type="checkbox"/> CCCMS <input type="checkbox"/> EOP <input type="checkbox"/> MHCB <input type="checkbox"/> Other		
Current Housing: <input type="checkbox"/> GP <input type="checkbox"/> ASU <input type="checkbox"/> SHU <input type="checkbox"/> PSU <input type="checkbox"/> RC <input type="checkbox"/> SNY <input type="checkbox"/> Other		
I/M Ethnicity (CDCR Designation):		Non-English Language:
I/M Ethnicity (Self-Designation): (Circle or Check all that apply) <ul style="list-style-type: none"> <li><input type="checkbox"/> Asian (Chinese, Vietnamese, Cambodian, Korean, Filipino, Japanese, Indian, Laos, Hong Kong, Thailand, other parts of Asia)</li> <li><input type="checkbox"/> Black (African American, Haitian, Creole and other Caribbean groups, African Immigrant)</li> <li><input type="checkbox"/> Hispanic (South American, Central American, Mexican, Cuban, Puerto Rican, Other)</li> <li><input type="checkbox"/> White (Caucasian, European, Russian, South African, Australian)</li> <li><input type="checkbox"/> Native American (Over 100 federally-recognized Indian tribes in California with about 40 Indian Groups seeking federal recognition; California Indians have dozens of languages and dialect from seven major language families: Hokan, Penutian, Algonkian, Shoshonean, Athabascan, Lutuamian, and Yukian)</li> <li><input type="checkbox"/> Other (Pacific Islander, Native Hawaiian, etc.)</li> <li><input type="checkbox"/> Unknown</li> </ul>		
Institution Arrival Date:	CDCR Arrival Date:	ERPD:    Cooperation: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
Sources of Information: <input type="checkbox"/> Inmate Interview <input type="checkbox"/> UHR <input type="checkbox"/> C-File <input type="checkbox"/> Staff Interview <input type="checkbox"/> Other		
<b>A. Presenting Problem:</b>		
<b>B. MH Past History:</b> <input type="checkbox"/> No Significant MH History <input type="checkbox"/> No Hx Psychiatric Medication <input type="checkbox"/> Outpatient Psychiatric <input type="checkbox"/> Inpatient Psychiatric <input type="checkbox"/> Outpatient Substance Abuse <input type="checkbox"/> Inpatient Substance Abuse <input type="checkbox"/> Suicide Attempts, #		
<b>C. Results of Risk Assessment:</b> <input type="checkbox"/> Suicidal <input type="checkbox"/> Assaultive <input type="checkbox"/> Other <input type="checkbox"/> See Detailed Documentation: From    Date		
<b>D. Check Current Problems:</b> <input type="checkbox"/> Appearance <input type="checkbox"/> Orientation <input type="checkbox"/> Behavior <input type="checkbox"/> Speech <input type="checkbox"/> Mood <input type="checkbox"/> Affect <input type="checkbox"/> Memory <input type="checkbox"/> Concentration <input type="checkbox"/> Delusions <input type="checkbox"/> Appetite <input type="checkbox"/> Sleep <input type="checkbox"/> Insight and Judgment		
<b>E. Evaluation, Mental Status, and Formulation:</b>		
<b>F. Diagnostic Impression:</b> <input type="checkbox"/> No DSM Diagnosis – Axis I <input type="checkbox"/> No Change – Copied from CDCR Form 7386 <input type="checkbox"/> <b>New Diagnosis</b> <input type="checkbox"/> No previous diagnosis <input type="checkbox"/> Referred to IDTT for change in diagnosis		
Axis I:		
Axis II:		GAF:
<b>G. Recommendation/Psychotropic Medication and Target Symptoms:</b>		
<input type="checkbox"/> Referral to MHSDS <input type="checkbox"/> Change LOC: <input type="checkbox"/> CCCMS <input type="checkbox"/> EOP <input type="checkbox"/> MHCB <input type="checkbox"/> APP <input type="checkbox"/> ICF <input type="checkbox"/> GP		
<input type="checkbox"/> Place in OHU <input type="checkbox"/> Placement Chrono Completed (if change in level of care)		
<input type="checkbox"/> Follow up:		
INSTITUTION:		CLINICIAN:
INMATE BED NUMBER:		DATE:
1. <u>Disability Code:</u> 2. <u>Accommodation:</u> 3. <u>Effective Communication:</u> <input type="checkbox"/> TABE score ≤ 4.0 <input type="checkbox"/> Additional time <input type="checkbox"/> P/I asked questions <input type="checkbox"/> DPH <input type="checkbox"/> DPV <input type="checkbox"/> LD <input type="checkbox"/> Equipment <input type="checkbox"/> SLI <input type="checkbox"/> P/I summed information <input type="checkbox"/> DPS <input type="checkbox"/> DNH <input type="checkbox"/> Louder <input type="checkbox"/> Slower <b>Please check one:</b> <input type="checkbox"/> DNS <input type="checkbox"/> DDP <input type="checkbox"/> Basic <input type="checkbox"/> Transcribe <input type="checkbox"/> Not reached* <input type="checkbox"/> Reached <input type="checkbox"/> Not Applicable <input type="checkbox"/> Other* <span style="float: right;">*See chrono/notes</span>		Inmate's Name (Last, First, MI), CDC Number, DOB
4. <u>Comments:</u>		

## INSTRUCTIONS

The Brief Mental Health Evaluation Form may be used whenever a brief mental health evaluation of an inmate is completed (e.g., at the time of medication evaluation by a psychiatrist, for regularly scheduled appointments, or for evaluation of an inmate-patient prior to Mental Health Crisis Bed referral). The form may be used instead of an Interdisciplinary Progress Note when a brief evaluation is conducted.

1. Fill in all relevant items on the form.
2. The handwriting must be legible. Print or type if necessary.
3. Indicate current housing and Level of Care. Check all boxes that apply. Indicate ethnicity and primary language. Indicate custody level I, II, III, IV. Enter date inmate arrived at CDCR for current term and earliest possible release date. Describe inmate's level of cooperation. Indicate source of information. Check all boxes that apply. If inmate does not speak English, indicate primary language.
  - A. Describe the inmate's current status, including problems and symptoms that prompted referral. If the inmate is in a mental health program and is being seen for a routine update, so state.
  - B. Mental Health Past History. Check all boxes that apply. Indicate the number of suicide attempts if applicable.
  - C. Results of Risk Assessment. Check all boxes that apply. Summarize risk and protective factors.
  - D. Present Mental Status. Check all boxes that are problematic. Further describe in Section E.
  - E. Narrative summary of findings of evaluation. Elaborate on any symptoms checked in Section D.
  - F. If a diagnosis is warranted, give DSM IV number and names of diagnoses. Check boxes to indicate if there is no diagnosis and whether the diagnosis listed is the same as previous diagnosis or is a change. If the diagnosis is different than the CDCR Form 7386, refer for review by an Interdisciplinary Treatment Team.
  - G. Recommendation. Describe recommended course of action. If a referral is being made to a treatment program, check box and indicate level of care. This should be accompanied by a Mental Health Placement Chrono, CDCR 128-MH3. Check box that chrono is completed. If a follow-up visit by a clinician is recommended, check box and indicate who should follow up and by what date. For evaluations conducted by a psychiatrist, include medications and target symptoms.
4. Clinician completing evaluation should sign form. Enter name of Institution, print clinician's name, enter inmate's current bed number, and date evaluation was completed.
5. At bottom of form, stamp with addressograph or print inmate's name, CDC number, and date of birth.
6. Complete the Effective Communication label at the bottom of the page. (This is required for all Armstrong inmate-patients only.). If no disability codes are required, check Not Applicable. No further action is required.
7. If more space is needed for any section, continue on an Add-a-Page, CDCR Form 7386, Page 7.

COUNTY MENTAL HEALTH WORKSHEET

INSTITUTION:

CDCR# <input type="text"/>	INMATE NAME (Last, First, MI):	DATE OF BIRTH:
COUNTY OF RESIDENCE:	RELEASE DATE:	SOCIAL SECURITY NUMBER:
SUPPLEMENTAL BENEFITS APPLIED FOR: <input type="checkbox"/> YES <input type="checkbox"/> NO	MEDI-CAL APPLICATION COMPLETED: <input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>CLINICAL INFORMATION</b>		
MENTAL HEALTH SERVICES DELIVERY SYSTEM LEVEL OF CARE ( check current level): <input type="checkbox"/> Outpatient <input type="checkbox"/> Day Treatment <input type="checkbox"/> Inpatient <input type="checkbox"/> DMH		
Clinical opinion shall be based on current functioning in the correctional setting as well as prior functioning, if known, in the community:		
1) Activities of Daily Living - the individual assessed should be capable of:		
a) Riding public transportation upon release without disorganization or disruptive behavior?	<input type="checkbox"/> yes	<input type="checkbox"/> no
b) Independently using a vehicle or local transit system to move within the community without getting lost or confused about his/her destination?	<input type="checkbox"/> yes	<input type="checkbox"/> no
c) Securing food, clothing, shelter and other essentials in a manner sufficient to sustain life?	<input type="checkbox"/> yes	<input type="checkbox"/> no
d) Making his or her healthcare needs known to others?	<input type="checkbox"/> yes	<input type="checkbox"/> no
e) Following doctor's orders, including taking medications as prescribed?	<input type="checkbox"/> yes	<input type="checkbox"/> no
(Explain any "NO" answers, from the section above, in the comments section)		
2) Mental Status		
a) At this time does the inmate-patient qualify as gravely disabled (unable to appropriately utilize food, clothing and/or shelter when provided)?	<input type="checkbox"/> yes	<input type="checkbox"/> no
b) Upon release from prison, will the individual likely qualify as gravely disabled (unable to provide for his/her own food, clothing and/or shelter)?	<input type="checkbox"/> yes	<input type="checkbox"/> no
c) At this time does the inmate-patient present a substantial physical danger to others?	<input type="checkbox"/> yes	<input type="checkbox"/> no
d) Does there exist a substantial threat of physical danger to a reasonably identifiable victim?	<input type="checkbox"/> yes	<input type="checkbox"/> no
• Has law enforcement been notified?	<input type="checkbox"/> yes	<input type="checkbox"/> no
e) At this time is the inmate-patient considered a danger to self?	<input type="checkbox"/> yes	<input type="checkbox"/> no
f) Would the individual benefit from a conservatorship if returned to the community by the projected parole date?	<input type="checkbox"/> yes	<input type="checkbox"/> no
(Explain any "Yes" answers from the section above, in the comments section)		
If a temporary conservatorship has been initiated or completed, describe in comments section		
3) Keyhea (involuntary medication)		
a) At this time is the inmate-patient involuntarily medicated per a <i>Keyhea</i> order? <input type="checkbox"/> yes <input type="checkbox"/> no		
If yes, the Keyhea is based on (check all that apply)		
<input type="checkbox"/> Danger to self <input type="checkbox"/> Danger to others <input type="checkbox"/> Grave Disability		
4) Medications (List name, route and dosage of currently prescribed medications)		
1.	3.	
2.	4.	
5) Not capable of using the following modes of transportation:		
<input type="checkbox"/> Public Transport <input type="checkbox"/> CDCR Transport (State Vehicle) <input type="checkbox"/> Ambulance <input type="checkbox"/> Family/Private Transport Arranged <input type="checkbox"/> Not Applicable		
6) Has the "Authorization for Release of Information" Form been signed by the Inmate/Patient? Yes <input type="checkbox"/> No <input type="checkbox"/>		
7) SPECIAL COMMUNICATION ASSISTANCE NEEDS: <input type="checkbox"/> None Indicated <input type="checkbox"/> Indicated (check all that apply).		
<input type="checkbox"/> No English Language <input type="checkbox"/> Limited English <input type="checkbox"/> Reading Grade Level ≤ 4.0		
<b>For Intellectual Impairment use:</b> <input type="checkbox"/> Simple Language <input type="checkbox"/> Assist Reading/Writing <input type="checkbox"/> Check for Understanding		
<b>For Hearing Impairment use:</b> <input type="checkbox"/> Hearing Aid <input type="checkbox"/> Sign Language <input type="checkbox"/> Louder Voice <input type="checkbox"/> Written Communication		
<b>For Vision Impairment use:</b> <input type="checkbox"/> Glasses <input type="checkbox"/> Magnifying Glass <input type="checkbox"/> Assist Reading and Writing		
8) Comments:		
Mental Health Primary Clinician (Print)		Date