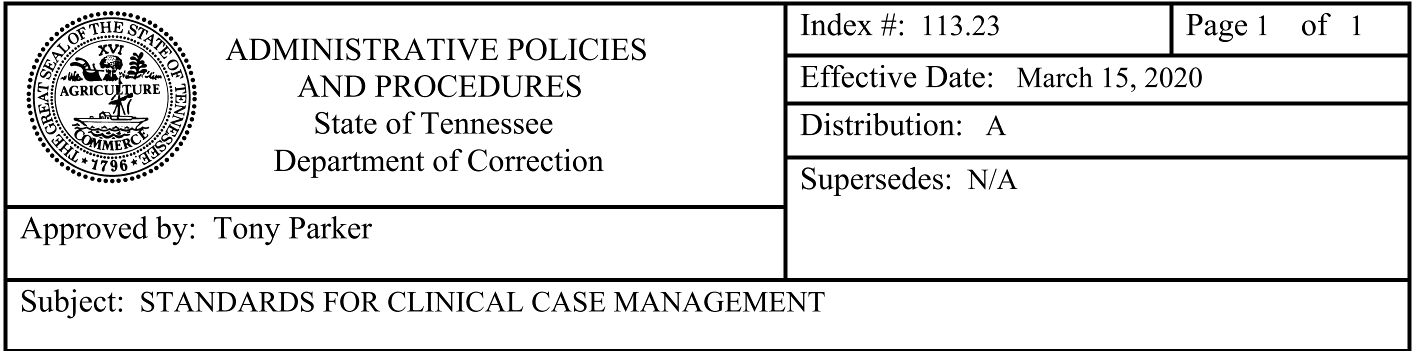

ADMINISTRATIVE POLICIES AND PROCEDURES State of Tennessee Department of Correction	Index #: 113.23	Page 1 of 1
	Effective Date: March 15, 2020	
	Distribution: A	
Approved by: Tony Parker	Supersedes: N/A	
Subject: STANDARDS FOR CLINICAL CASE MANAGEMENT		

POLICY CHANGE NOTICE 20-6

INSTRUCTIONS:

Please change Section VI.(E)(12) to read as follows:

"12. Forensic Social Workers (FSW)

a. The clinical case manager shall complete Forensic Referral Social Worker, CR-3927, and forward to the appropriate FSW Supervisor to request an appointment date and time with the assigned FSW prior to their final meeting with the offender.

b. The FSW Supervisor shall forward the clinical case manager the date, time, and location of the offender's FSW appointment in the community.

c. The clinical case manager shall ensure this information is shared with the offender along with the date, time and location for any community mental health appointments.

d. Prior to offender's departure from the institution the clinical case manager shall forward the Discharge Mental Health Summary, CR-3616, including the date, time and location for any community mental health appointments to the appropriate FSW Supervisor.

e. In the event that an inmate refuses coordination of mental health services, the clinical case manager will forward the Refusal of Medical Services, CR-1984, to the FSW supervisor in the location of the offender's release".

Please insert the attached page 8 and renumber all policy pages accordingly.

TENNESSEE DEPARTMENT OF CORRECTION
HEALTH SERVICES
REFUSAL OF MEDICAL SERVICES

INSTITUTION: ____________________________________

Date _______________ 20 _____ Time __________ AM/PM

This is to certify that I ____________________(Inmate's Name)____________________, __________(TDOC ID)__________

have been advised that I have been scheduled for the following medical services and/or have been advised to have the following evaluations, treatment, or surgical/other procedures:

____

____

____

I am refusing the above listed medical services against the advice of the attending physician and/or the Health Services staff. I acknowledge that I have been informed of the risks involved by my refusal and hereby release the State of Tennessee, Department of Correction, and their employees from all responsibility for any ill effects which may be experienced as a result of this refusal. I also acknowledge this medical service may not be made readily available to me in the future unless an attending physician certifies my medical problem as a medical emergency.

Signed: ______________________ ______________________ ______________________
(Inmate) (TDOC ID) (Date)

Witness: ______________________ ______________________ ______________________
(Signature) (Title) (Date)

The above information has been read and explained to,

______________________ ______________________ but has refused to sign
(Inmate's Name) (TDOC ID)
the form.

Witness: ______________________ ______________________ ______________________
(Signature) (Title) (Date)

Witness: ______________________ ______________________ ______________________
(Signature) (Title) (Date)

TENNESSEE DEPARTMENT OF CORRECTION
DISCHARGE MENTAL HEALTH SUMMARY

____
INSTITUTION

RE: _______________________________ PATIENT NAME _______________ TDOC ID

_______________ DATE OF BIRTH _______ AGE _______ SEX

DIAGNOSED WITH:
☐ **SERIOUS MENTAL ILLNESS (SMI)** ☐ **SERIOUS AND PERSISTENT MENTAL ILLNESS (SPMI)** ☐ **NONE OF THE ABOVE**

LEVEL OF CARE: _______________________________

D5M5 DISCHARGE DIAGNOSIS: _______________________________

CONSERVATOR ☐ **YES** ☐ **NO:**

Conservator Contact Name: _______________________ Telephone: _______________
Address: _______________________________

CURRENT MEDICATIONS:

NAME	DOSAGE	FREQUENCY	PRESCRIBING DOCTOR

Community Appointment

_______ Date _______ Time _______ Agency

Recommendations:
Mental Health Services ☐ Yes ☐ No
Substance Use Services ☐ Yes ☐ No If yes, please explain: _______________

Comment(s): _______________________________

_______________________________ STAFF SIGNATURE _______________ DATE

_______________________________ STAFF NAME (PRINTED)

This information has been disclosed to you for use in your official capacity, from records for which confidentiality is protected by law. See Tennessee Code Annotated 10-7-504(a) (1). See also Title 42 CFR Part 2, where applicable. Further disclosure of this information without the subject's specific authorization is prohibited.