ADMINISTRATIVE POLICIES AND PROCEDURES State of Tennessee Department of Correction	Index #: 113.81	Page 1 of 18
	Effective Date: February 15, 2022	
	Distribution: A	
Approved by: Lisa Helton	Supersedes: 113.81 (5/15/18)	
Subject: MENTAL HEALTH DOCUMENTATION		

I. AUTHORITY: TCA 4-3-603 and TCA 4-3-606.

II. PURPOSE: To ensure standardized procedures for all required documentation of mental health service delivery.

III. APPLICATION: All Tennessee Department of Correction (TDOC) employees, including contracted health and mental health care professionals/agencies and privately managed facilities.

IV. DEFINITIONS:

A. Health Record: A chronological documentation of an inmate's clinical history and treatment. The record includes, but is not limited to, documentation of intake health screenings, progress notes, x-ray and laboratory reports, physicians' orders, clinic and infirmary records, medication administration records, treatment plans, immunization records, dental records, hospital and emergency room reports, specialty consultation reports, and mental health records.

B. Mental Health Programmatic Record: An extension of the health record which compiles all of the offender's history and progress in treatment, as well as any other documentation pertaining to the programmatic services delivered to the inmate.

C. Mental Health Treatment Services: Biological and psychological therapies available to treat mental health disorders that significantly interfere with the inmate's ability to function in prison. Treatment is multidisciplinary, eclectic, and consistent with generally accepted mental health practices and institutional requirements.

D. Mental Health Treatment Team: For purposes of this policy, a multidisciplinary team consisting of qualified mental health professionals and mental health adjunct personnel who are responsible for the development, implementation, monitoring, supervision, review, and documentation of a mental health treatment plan for individual inmates/patients who are determined to be in need of mental health services.

E. Programmatic Services: Mental health services provided by licensed/qualified mental health professionals and adjunct staff under the guidelines of a structured mental health program, i.e., sex offender, anger management, etc., which address a single treatment issue in a program setting designed to address special treatment needs.

V. POLICY: Each institution shall utilize a standardized documentation process to provide continuity of care in the delivery of mental health services.

VI. PROCEDURES:

A. General:

1. All personnel responsible for providing mental health service intervention(s) shall routinely enter into the offender management system (OMS) Mental Health Conversation, LHSM, the appropriate service code(s), and applicable text for each inmate/patient served. Service codes entered into LHSM will be monitored by central office mental health service staff and utilized for periodic reporting. Those providing data entry assistance to contract service providers shall be provided with appropriate OMS access.

2. Inmates who are diagnosed utilizing the most current DSM standards shall have their diagnosis entered into the OMS, Services Provided (LOEL). Upon completion of a psychiatric/psychological evaluation, a new diagnostic code may be entered for a patient to reflect the most accurate diagnosable disorder. Existing diagnostic entries shall not be modified.

3. Physician orders shall be documented in accordance with Policies #113.70 and/or #113.71.

B. Health Record: A health record for each inmate shall be maintained in accordance with Policy #113.50 and shall contain accurate documentation of all health care services provided throughout the inmate's entire period of incarceration. All mental health services documentation will be located in section 10 of the health record and shall be stored in chronological order as it relates to services provided. Providers with illegible signatures must print their names/titles in addition to a handwritten signature. Photocopies of signatures are not acceptable.

Below is a list of mental health forms and documents utilized by mental health staff, mental health consultants, and other applicable personnel. All are reserved for the mental health record.

1. Problem-Oriented - Progress Record, CR-1884
2. Consent for Treatment, CR-1897
3. Monitoring Report, CR-2004
4. Mental Health Screening Report, CR-2629
5. Mental Health Seclusion/Suicide/Restraint Authorization, CR-3082
6. Mental Health Treatment Plan, CR-3326
7. Mental Health Summary, CR-3327
8. Mental Health Treatment Review Committee, CR-3329
9. Mental Health Emergency Medication, CR-3330
10. Certification of Mental Health Emergency, CR-3388
11. Institutional Mental Health Services Referral, CR-3431

12. Mental Health Psychiatric Update, CR-3487

13. Individual Psychiatry Session - Progress Record, CR-3763

14. Individual/Group Therapy Session-Progress Record Psychology Services, CR-3764

15. Mental Health Discharge Summary, CR-3765

16. Mental Health Treatment Plan Review, CR-3767

17. Mental Health Intake Appraisal and Evaluation, CR-4180

18. Past Mental Health History & Reports

19. Release to Community Mental Health/Agency Documentation

20. Court order for conservator (See Policy #113.89)

21. Mental health information received from other facilities community agencies

C. Mental Health Programmatic Record: The programmatic record shall be utilized as an extension of the health record for the documentation of mental health treatment services. The health record shall continue to be the site for the documentation of mental health clinical services. It is not necessary to create a separate programmatic record for special needs mental health patients at DSNF and DJRC.

1. Each TDOC facility shall develop an in-house procedure to ensure that the institutional records office staff is made aware that a programmatic record exists.

2. Confidentiality and release of programmatic records shall be handled in accordance with Policy #113.52.

3. It is acceptable for an inmate/patient to have more than one programmatic record if he/she is involved in multiple programs. The drug treatment coordinator shall be responsible for maintaining accurate program records.

4. All members of a mental health treatment team shall have access to the programmatic record and shall use this record as the site for documentation of all mental health treatment services delivered to the inmate/patient.

5. All active programmatic records shall be stored in a locked, secure area. Upon an inmate's program completion, all programmatic records shall be merged with the health record.

6. Access to the records shall be strictly controlled:

a. A list of TDOC staff who are authorized to access the files shall be maintained with the records by the Behavioral Health Administrator and the Health Services Administrator. Access will only be granted to clinical staff who are involved in the patient's care, the Warden, and the Associate Warden of Treatment.

b. Any TDOC staff member seeking access to the records shall secure approval from the treating mental health professional and shall demonstrate a "need to know."

7. The left section of the opened programmatic record can be used for the placement of the following types of information as deemed necessary by program staff.

    a. Historical information pertinent to treatment, such as pre-sentence investigation reports, facts of offense, and miscellaneous community treatment reports

    b. Photocopies of psychiatric/psychological evaluations, assessments, and recommendations

8. The right section of the opened programmatic record (if applicable) is reserved for the following forms:

    a. Programmatic Daily/Weekly/Monthly Group Summary, CR-3491.

    b. Psychiatric Daily/Weekly/Monthly Group Summary, CR-3490.

    c. All progress notes documenting treatment staff contacts, behavioral observations, and services.

    d. All completed autobiographies, assignments, or related written reports by the inmate, filed with the related progress note(s).

    e. All programmatic treatment plans and/or Individual Program Plans generated during the course of mental health intervention.

    f. All mental health treatment team discussions and decisions related to the inmate's progress in treatment and treatment status.

D. Retention/Disposition:

1. All inactive records of inmates shall be maintained separate from the active inmate records, following the same procedures on storage, access, disposition, and release of the health record as indicated by Policy #113.50. All inactive parole evaluations or forensic evaluations shall be disposed of as indicated in Policy #113.50.

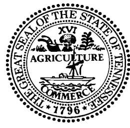
2. When an inmate transfers from a facility, the programmatic record(s) will be forwarded to the receiving facility's mental health staff immediately.

3. Federally funded treatment programs may require special programmatic record retention and disposition procedures that will be detailed in memorandum format from the respective Central Office Director.

4. Psychological test protocols for intake and other purposes shall be retained at the testing facility in a secure and confidential file for three years.

VII. ACA STANDARDS: 5-ACI-1E-01, 5-ACI-6A-28, 5-ACI-6D-04, 5-ACI-6D-05, 5-ACI-6D-06, and 5-ACI-6D-07.

VIII. EXPIRATION DATE: February 15, 2025



TENNESSEE DEPARTMENT OF CORRECTION

PROBLEM ORIENTED – PROGRESS RECORD

____
INSTITUTION

INMATE NAME: __________________________________ TDOC ID: ________________________

DATE	TIME	

Do Not Write on Back

TENNESSEE DEPARTMENT OF CORRECTION
HEALTH SERVICES
CONSENT FOR TREATMENT

____
INSTITUTION

Name: ____________________________ TDOC ID: ______________ Date of Birth: ______________
Last First Middle

I hereby authorize ________________________ and assistants to perform the following operation, procedure,
(Practitioner)
treatment, or psychiatric intervention.

____
Use Laymans Terms

The nature and extent of the intended operation, procedure, treatment, or psychiatric intervention has been explained to me in detail. I have been advised by ____ of the following
(Practitioner)
alternatives, if any, probable consequences if I remain untreated, risks and possible complications of proposed treatment as indicated:

____
(Use Layman's Terms)

I acknowledge that no guarantee or assurance has been made as to the result that may be obtained.

If any unforeseen condition arises in the course of the operation calling for the judgment of the practitioner for procedures in addition to or different from those now contemplated, I further request and authorize the practitioner to do whatever is deemed necessary.

I consent to the administration of anesthesia to be applied under the direction and supervision of _____________.
(Practitioner)

I have read and fully understand the terms of this consent and acknowledge that the explanations referred to were made and that all blanks have been filled.

Date: ________________ Time: ______________ ________________________________
(Signature of Patient)

Witness: __________________________ __________________________________ ____________
(Signature of Practitioner and Professional Title) Date

If the patient is a minor or incompetent to consent:

____ Date: ___________ Time: ______________ a.m p.m.
(Signature of parent or person authorized to consent for patient)

Witness: ______________________________ Witness: ______________________________

Duplicate as Needed
Original: Health Record

TENNESSEE DEPARTMENT OF CORRECTION
MONITORING REPORT

BHA Review ______ **Initials** **Date**

INSTITUTION ____________________

INMATE: ____________________ **TDOC ID:** ____________ **LOCATION:** __________

SPECIAL INSTRUCTIONS:

____

COMMENTS/BEHAVIOR OBSERVED

COMMENTS: Indicate restraints loosened, which limbs exercised, food/fluid intake and amount, fluid output, toileting, ADLs, etc.

ACTIVITY CODE LIST: _Use abbreviations below_

1. Other (See Comment)
2. Loud
3. Delusional
4. Hallucinating
5. Crying
6. Inappropriate Laughter
7. Incontinent
8. Restless/Pacing
9. Rocking of body
10. Hostile/Threatening
11. Swearing/Name Calling
12. Fighting Restraints
13. Kicking
14. Punching: a. Door b. Wall
15. Self Mutilation
16. Smearing Excrement
17. Spitting
18. Incoherent
19. Talking
20. Glaring
21. Quiet
22. Sleeping (+ chest movement)
23. Inappropriate Sexual gestures:
    a. Disrobing
    b. Masturbating
24. Hygiene: a. Oral b. Shave
    c. Shower d. Bath
    Nutrition:
25. a. Fluid Encouraged (q ___hr)
    b. Assisted w/diet while awake
    c. Refused Nutrition
26. Appetite: a. Good b. Fair c. Poor
27. Restraint(s)
    a. 4 Point: Leather ☐ Soft ☐ Vinyl ☐
    Other: _____
    Wrist: Right ☐ Left ☐
    Ankle: Right ☐ Left ☐
    b.Vest
    c. Helmet
28. Circulation checked
29. Exercise (q ___hr)
    a. ROM ea. Extremity
    b. Position Changed
    c. Ambulate
    d. Discontinued Restraints
30. Offer Toileting
31. Skin: a. Assessed intact
    b. Assessed _(See Comments)_

DATE	TIME	ACTIVITY CODE(S)	INITIAL	DATE	TIME	ACTIVITY CODE(S)	INITIAL	DATE	TIME	ACTIVITY CODE(S)	INITIAL

INITIAL	SIGNATURE/TITLE	INITIAL	SIGNATURE/TITLE	INITIAL	SIGNATURE/TITLE

MONITORING REPORT

____
INSTITUTION

INMATE/PATIENT: ______________________ **TDOC ID:** ______________ **DOB:** __________

DATE	TIME	ACTIVITY CODE(S)	INITIAL	DATE	TIME	ACTIVITY CODE(S)	INITIAL	DATE	TIME	ACTIVITY CODE(S)	INITIAL

INITIAL	SIGNATURE/TITLE	INITIAL	SIGNATURE/TITLE	INITIAL	SIGNATURE/TITLE

TENNESSEE DEPARTMENT OF CORRECTION
MENTAL HEALTH SCREENING REPORT FOR SEGREGATION

____
INSTITUTION

INMATE NAME: ____________ TDOC ID: ____________ GENDER: ____________

UNIT: ________ TIME: ________ CELL: ________ DATE OF SCREENING: ________

TYPE OF SCREENING: 72 HOUR SEGREGATION ___ 7 DAY SEGREGATION: ___ 30 DAY SEGREGATION ___ OTHER: ________

MENTAL STATUS SCREENING:

YES	NO	
☐	☐	DOES THE OFFENDER HAVE A PRESENT SUICIDE IDEATION
☐	☐	DOES THE OFFENDER HAVE A HISTORY OF SUICIDAL BEHAVIOR
☐	☐	IS THE OFFENDER PRESENTLY PRESCRIBED PSYCHOTROPIC MEDICATION
☐	☐	DOES THE OFFENDER HAVE A CURRENT MENTAL HEALTH COMPLAINT
☐	☐	IS THE OFFENDER BEING TREATED FOR MENTAL HEALTH PROBLEMS
☐	☐	DOES OFFENDER HAVE A HISTORY OF TREATMENT FOR SUBSTANCE USE
☐	☐	DOES OFFENDER HAVE A HISTORY OF INPATIENT AND OUTPATIENT PSYCHIATRIC TREATMENT

SUBJECTIVE/OBJECTIVE (include symptoms of psychosis, depression, anxiety, and/or aggression) : ____________

____

____

____

GENERAL APPEARANCE

- ☐ Neat
- ☐ Unclean
- ☐ Bizarre
- ☐ Disheveled

EYE CONTACT

- ☐ Good
- ☐ Fair
- ☐ Poor

DISPOSITION OF OFFENDER

- ☐ No Mental Health Referral
- ☐ Referral to Mental Health Care Service
- ☐ Referral to Appropriate Mental Health Care Service for Emergency Treatment

ADDITIONAL INFORMATION: ______________________________

____

____

SIGNATURE OF MENTAL HEALTH PROVIDER	TITLE	DATE

TENNESSEE DEPARTMENT OF CORRECTION
MENTAL HEALTH SECLUSION/SUICIDE/RESTRAINT AUTHORIZATION

____
INSTITUTION

PATIENT: ______________ TDOC ID: ______________ DATE OF BIRTH: ______________

PRECIPITATING SYMPTOMS (OBSERVATION/JUSTIFICATION): ______________

ASSESSMENT: ______________

INITIAL ORDER: ______________

TIME OF AUTHORIZATION: ______________ ______________ DATE

TELEPHONE ORDER: ______________ SIGNATURE OF ASSIGNED OR SUPERVISING NURSE

______________ SIGNATURE OF ORDERING PSYCHIATRIST/CNS ______________ DATE ______________ SIGNATURE/TITLE OF AUTHORIZING STAFF ______________ DATE

TYPE OF PLACEMENT: ☐ SECLUSION ☐ SUICIDE WATCH ☐ RESTRAINTS LOCATION: ______________

IF RESTRAINT, TYPE: ______________ TIME OF APPLICATION: ______________ DATE:

REASSESSMENT: ______________

TYPE OF PLACEMENT: ☐ SECLUSION ☐ SUICIDE WATCH ☐ RESTRAINTS

EXTENSION ORDER: ______________

TELEPHONE CONSULTATION: ______________

TIME OF REASSESSMENT: ______________ DATE: ______________ ______________ SIGNATURE/TITLE OF AUTHORIZED STAFF

REASSESSMENT: ______________

TYPE OF PLACEMENT: ☐ SECLUSION ☐ SUICIDE WATCH ☐ RESTRAINTS

EXTENSION ORDER: ______________

TELEPHONE CONSULTATION: ______________

TIME OF REASSESSMENT: ______________ DATE: ______________ ______________ SIGNATURE/TITLE OF AUTHORIZED STAFF

ORIGINAL: HEALTH RECORD **CANARY: PROGRAMMATIC RECORD**

MENTAL HEALTH SECLUSION/SUICIDE/RESTRAINT AUTHORIZATION

____
INSTITUTION

PATIENT: ____________ TDOC ID: ____________ DATE OF BIRTH: ____________

REASSESSMENT: ______________________________

TYPE OF PLACEMENT: ☐ SECLUSION ☐ SUICIDE WATCH ☐ RESTRAINTS
EXTENSION ORDER: ______________________________
TELEPHONE CONSULTATION: ______________________________
TIME OF REASSESSMENT: ____________ DATE: ____________ ____________
SIGNATURE/TITLE OF AUTHORIZED STAFF

REASSESSMENT: ______________________________

TYPE OF PLACEMENT: ☐ SECLUSION ☐ SUICIDE WATCH ☐ RESTRAINTS
EXTENSION ORDER: ______________________________
TELEPHONE CONSULTATION: ______________________________
TIME OF REASSESSMENT: ____________ DATE: ____________ ____________
SIGNATURE/TITLE OF AUTHORIZED STAFF

REASSESSMENT: ______________________________

TYPE OF PLACEMENT: ☐ SECLUSION ☐ SUICIDE WATCH ☐ RESTRAINTS
EXTENSION ORDER: ______________________________
TELEPHONE CONSULTATION: ______________________________
TIME OF REASSESSMENT: ____________ DATE: ____________ ____________
SIGNATURE/TITLE OF AUTHORIZED STAFF

ORDER DISCONTINUED: ______________________________
TIME OF DISCONTINUANCE: ____________ DATE: ____________ ____________
SIGNATURE/TITLE OF AUTHORIZED STAFF

TIME OF DISCONTINUANCE: ____________ DATE: ____________ ____________
SIGNATURE PSYCHIATRIST / CNS

TENNESSEE DEPARTMENT OF CORRECTION
MENTAL HEALTH TREATMENT PLAN

INSTITUTION

INMATE:

TDOC ID:

DATE OF BIRTH:

GENDER:

TREATMENT PLAN REVIEW DUE ON:

☐ VOLUNTARY ☐ INVOLUNTARY ☐ LEVEL OF CARE

☐ INPATIENT ☐ OUTPATIENT

SPECIAL UNIT: SPECIFY:

LEVEL OF CARE: ☐ II ☐ III ☐ IV ☐ V

DSM-5 DIAGNOSIS:

TARGET SYMPTOMS/PROBLEMS:

1)
2)
3)
4)
5)

GOALS ACCORDING TO PROBLEM # ABOVE/INMATE RESPONSIBILITIES:

1)
2)
3)
4)
5)

TREATMENT MODALITY AND FREQUENCY TO ACHIEVE GOALS:

INMATE SIGNATURE / CONSERVATOR SIGNATURE — DATE

STAFF SIGNATURE — TITLE — DATE

STAFF SIGNATURE — TITLE — DATE

RECEIVING PROVIDER — DATE

TENNESSEE DEPARTMENT OF CORRECTION
MENTAL HEALTH TREATMENT REVIEW COMMITTEE
DEBERRY SPECIAL NEEDS FACILITY

INMATE NAME: ____________________ TDOC ID: __________ DATE OF BIRTH: __________ GENDER: ______

I. REPORT OF INITIAL PSYCHIATRIST'S MEETING WITH INMATE'S:

Initial Psychiatrist's Recommendation(s):

____ ____________________
Psychiatrist Signature Date

II. REPORT OF SECOND PSYCHIATRIST'S MEETING WITH INMATE:

Second Psychiatrist's Recommendation(s):

____ ____________________
Psychiatrist Signature Date

III. REPORT OF TREATMENT TEAM MEETING:

Treatment Team Recommendations(s):

White – Inmate's Health Record Canary – Treatment Team Coordinator Pink – Inmate Rights Advocate

IV. REPORT OF TREATMENT REVIEW COMMITTEE:

Signature of Treatment Review Committee:	Date	Comments:
______________________ Title	__________	______________
______________________ Title	__________	______________
______________________ Title	__________	______________

INMATE RIGHTS ADVOCATE COMMENT(S):

____
Inmate Rights Advocate Signature

____
Date

TENNESSEE DEPARTMENT OF CORRECTION
MENTAL HEALTH SUMMARY

____
INSTITUTION

INMATE NAME: ____ TDOC ID: ________________
Last First Middle

DOB: ____________ Gender: ______ Race ______ Custody Status: ________ Release Date: ____________

FOLLOW-UP APPOINTMENT DATE:: ____

REFERRAL TO RECEIVING FACILITY (Contact Person): ________________________________

COMMUNITY MENTAL HEALTH CENTER (Specify Branch) Telephone/Address: ____________________

DSM DIAGNOSIS: ____

HISTORY OF SUICIDAL OR SELF-INJURIOUS BEHAVIORS: ____________________________

ASSESSMENT [Problem(s), Behavioral Observations, Clinical Impressions, Estimation of Intellectual Ability, MSE): ________

TRIGGERS AND/OR EARLY WARNING SIGNS OF DECOMPENSATION: ________________________

PATIENT INSIGHT/MOTIVATION/COMPLIANCE: ________________________________

PRIOR TREATMENT HISTORY: ____

FUTURE TREATMENT RECOMMENDATIONS: ________________________________

____ ____________________
Signature of Staff Date

____ ____________________
Signature of Staff Date

TENNESSEE DEPARTMENT OF CORRECTION
MENTAL HEALTH EMERGENCY MEDICATION

____
INSTITUTION

INMATE NAME: ________________ TDOC ID: __________ D.O.B ____________ GENDER: ____________

I, the undersigned physician, prescribe and authorize the administration of the following psychotropic medication to the above named inmate: ____
(Medication)

I conclude that an emergency exists because of the following circumstances:

__________ an immediate threat of serious physical harm to the inmate or to others as a result of the violent behavior of the inmate: Specific Behaviors:

____

____

__________ an immediate threat to the inmate of deteriorating physical well-being with risk to life or long-term health caused by the effects of mental illness: Specific Behaviors:

____

____

I have personally observed these behaviors with a persistence of immediate threats.

The following less restrictive measures were considered/attempted but rejected as ineffective:

____

____

The certification of emergency and prescription and authorization for administration of psychotropic medication based on emergency shall be effective only for (72) seventy-two hours beginning at the time and date indicated below:

______________________ a.m. / p.m.	______________	______________________
Time of First Administration	Date	Signature of Physician Certifying Emergency

NOTE: By the end of the next regular working day, the physician shall make sure that a copy of this form has reached the: (a) inmate's health record; (b) treatment team coordinator; (c) Inmate Rights Advisor, and; (d) the warden.

EMERGENCY RENEWAL

I, the undersigned physician, have determined that the above-certified emergency continues to exist beyond the original (72) seventy-two hour period indicated above, and I extend the prescription and authorization noted for an additional (72) seventy-two hours, creating an emergency medication period totaling one-hundred forty-four (144) hours.

As a result of my personal evaluation of the inmate, within (6) six hours of renewal, I have concluded that an emergency situation continues to exist because:

____

____

____

__________ a.m. / p.m.	__________	______________	______________
Time	Date	Facility	Signature of Physician

White – Inmate's Health Record Canary – Treatment Team Coordinator Pink – Inmate Rights Advocate

TENNESSEE DEPARTMENT OF CORRECTION

CERTIFICATION OF MENTAL HEALTH EMERGENCY

____

INSTITUTION

______________________	______________	______________	______
Inmate/Patient	TDOC ID	Date of Birth	Gender

I, the undersigned physician or psychologist, conclude that an emergency exists because of the following circumstances: (check as indicated)

______________ an immediate threat of serious physical harm to the inmate/patient or to others as a result of the violent behavior of the inmate/patient. Specific behaviors include:

____

____

____

______________ an immediate threat to the inmate/patient of deteriorating physical well-being with risk to life or long-term health caused by the effects of mental illness. Specific behaviors include:

____

____

____

I have personally observed these behaviors with a persistence of immediate threats.

The following less restrictive measures were considered/attempted but rejected as ineffective:

____

____

____

The certification of a mental health emergency requiring a transfer to the DeBerry Special Needs Facility or to an outside health care provider has been based on my direct assessment of this inmate/patient.

______________________	______________	______________
Signature	Title	Date

TENNESSEE DEPARTMENT OF CORRECTION
INSTITUTIONAL HEALTH SERVICES REFERRAL

____
INSTITUTION

☐ MEDICAL ☐ DENTAL
☐ BEHAVIORAL HEALTH

INMATE: ____ TDOC ID: ______________
Last First Middle

PRESENTING PROBLEMS: ____

REFERRED BY: ______________________________ ______________ ______________
Signature/Title Date Time

SEND REFERRAL FORM TO INSTITUTIONAL HEALTH COORDINATOR

☐ Behavioral Health
☐ Medical ☐ Dental

RECEIVED BY: ______________________________ ______________ ______________
Signature/Professional Title Date Time

REFERRAL DISPOSITION (Course of Action): ________________________________

______________________________ DATE: ______________ TIME: ______________

____
Signature/Professional Title

TENNESSEE DEPARTMENT OF CORRECTION
PSYCHIATRIC UPDATE

____
INSTITUTION

INMATE NAME: ______________________________ TDOC ID: ______________
Last First Middle

DOB: __________ Gender: ______ Race ______ Custody Status: __________ Date: __________

COURSE OF TREATMENT TO DATE

Define Problem Areas: ______________________________

Psychotropic Medications:

Last Psychiatrist Visit: ______________________________

CURRENT MENTAL STATUS

History of suicide attempts in the past year: ☐ Yes ☐ No How many? __________

DIAGNOSTIC IMPRESSIONS

DSM-V: ______________________________

TREATMENT RECOMMENDATIONS: ______________________________

______________________________ ______________
Staff Psychiatrist Signature Date

______________________________ ______________
Staff Psychologist Signature Date

______________________________ ______________
Staff Signature/Title Date

TENNESSEE DEPARTMENT OF CORRECTION
MENTAL HEALTH SERVICES
PSYCHIATRIC DAILY/WEEKLY/MONTHLY GROUP SUMMARY

____
INSTITUTION

INMATE NAME: ______________________________ TDOC ID: ______________________

TREATMENT GROUP: __________________________ DATE: FROM: __________ TO: __________

	Poor	Fair	Good	Excellent	N/A
	S M T W T F S	S M T W T F S	S M T W T F S	S M T W T F S	S M T W T F S
1. Patient's level of hygienic appropriateness	☐☐☐☐☐☐☐	☐☐☐☐☐☐☐	☐☐☐☐☐☐☐	☐☐☐☐☐☐☐	☐☐☐☐☐☐☐
2. Patient's orientation to task(s):	☐☐☐☐☐☐☐	☐☐☐☐☐☐☐	☐☐☐☐☐☐☐	☐☐☐☐☐☐☐	☐☐☐☐☐☐☐
3. Participative Level:	☐☐☐☐☐☐☐	☐☐☐☐☐☐☐	☐☐☐☐☐☐☐	☐☐☐☐☐☐☐	☐☐☐☐☐☐☐
4. Cognitive processing:	☐☐☐☐☐☐☐	☐☐☐☐☐☐☐	☐☐☐☐☐☐☐	☐☐☐☐☐☐☐	☐☐☐☐☐☐☐
5. Emotional functioning:	☐☐☐☐☐☐☐	☐☐☐☐☐☐☐	☐☐☐☐☐☐☐	☐☐☐☐☐☐☐	☐☐☐☐☐☐☐

DAILY/WEEKLY GROUP NOTES:

Date ____________ Objective/Focus ________________ Observations ____________________

______________________________ Staff Signature ______________________________

Date ____________ Objective/Focus ________________ Observations ____________________

______________________________ Staff Signature ______________________________

Date ____________ Objective/Focus ________________ Observations ____________________

______________________________ Staff Signature ______________________________

Date ____________ Objective/Focus ________________ Observations ____________________

______________________________ Staff Signature ______________________________

Date ____________ Objective/Focus ________________ Observations ____________________

______________________________ Staff Signature ______________________________

WEEKLY/MONTHLY SUMMARY: ____

Signature(s) and Title of Therapist/Mental Health Staff

______________________________ DATE: ____________________

______________________________ DATE: ____________________

TENNESSEE DEPARTMENT OF CORRECTION
MENTAL HEALTH SERVICES PROGRAMMATIC - PROGRESS RECORD

____
INSTITUTION

Inmate Name: ______________________________ TDOC ID: ______________________

PSYCHOLOGY SERVICES – Weekly Group Session

DATE	
	TARGET SYMPTOMS/PROBLEM:
WEEK ENDING:	**TREATMENT GROUP:**
	MENTAL STATUS: INDICATE SIGNIFICANT CHANGES IN FOLLOWING AREAS:
MONTH ENDING:	Speech ☐ No ☐ Yes | If yes, please explain: _____
	Thought Processes: ☐ No ☐ Yes | If yes, please explain: _____
	Sleep ☐ No ☐ Yes | If yes, please explain: _____
	Hallucinations ☐ No ☐ Yes: If yes, please explain: _____
	Delusions: ☐ No ☐ Yes If yes, please explain: _____ Affect: ☐ No ☐ Yes If yes, please explain: _____
	Mood ☐ No ☐ Yes If yes, please explain: _____
	Cognitive Functions: ☐ No ☐ Yes If yes, please explain: _____
	Danger to Self or Others ☐ Not Present ☐ Suicidal ☐ Homicidal ☐ Assaultive ☐ Self Injurious
	PARTICIPATION: ☐ Cooperative ☐ Guarded/Resistant ☐ Easily Distracted ☐ Focused ☐ Engaged ☐ Not Engaged ☐ Receptive
	PATIENT MED ISSUES:
	☐ Not On Medication for Mental Health Purposes ☐ Compliant with Current Regimen As Prescribed ☐ Non-compliant with Current Regimen Reported Side Effects: _____
	Level of Functioning:
	Behavior: ☐ Isolative ☐ Poor Impulse Control ☐ Hostile/Angry ☐ Interpersonal Conflict ☐ Appropriate to Situation
	UPDATE REGARDING INMATE'S RESPONSE TO CLINICAL INTERVENTIONS AND THERAPUETIC CARE ACTIVITIES, PROGRESS TOWARD MEETING GOALS AND OBJECTIVES, AND ANY CHANGES REQUIRED:
	ASSESSMENT:
	☐ Good Progress ☐ Stable/Maintaining ☐ No Progress ☐ Decompensation
	PLAN:
	☐ Return For Group Session. ☐ Refer to Psychiatry ☐ Terminate Group Services.

______________________________ ______________________
Signature / Print Date

TENNESSEE DEPARTMENT OF CORRECTION
MENTAL HEALTH SERVICES
INDIVIDUAL PSYCHIATRY SESSION – PROGRESS RECORD

Institution: ____________________

NAME: ____________________ **TDOC ID:** ____________________

DATE: **TIME:**

S = SUBJECTIVE **O** = OBJECTIVE **A** = ASSESSMENT **P** = PLAN

☐ **Interim** ☐ **90-day** ☐ **12-month**

S (SUBJECTIVE): SPMI ☐ YES SMI ☐ YES DIAGNOSIS

O (OBJECTIVE): Orientation	Memory	Speech	Thought Processes	Sleep	Hallucinations	Eye Contact
☐ O X 4 ☐ Not Person ☐ Not Place ☐ Not Time ☐ Not Situation ☐ Other	☐ Intact ☐ Memory Deficit	☐ Appropriate ☐ Rapid ☐ Pressured ☐ Slowed ☐ Mute ☐ Tangential ☐ Perseverating	☐ Appropriate ☐ Loose Assoc ☐ Flight of Ideas ☐ Expansive ☐ Pessimistic	☐ No Complaint ☐ Hypersomnia ☐ Insomnia ☐ Nightmares ☐ Changes in sleep pattern	☐ Not Present ☐ Tactile ☐ Olfactory ☐ Gustatory ☐ Auditory ☐ Visual	☐ Good ☐ Fair ☐ Poor

Comments: ____________________

Delusions	Mood	Affect	Danger to Self or Others	AIMS
☐ Not Present ☐ Grandiose ☐ Persecution ☐ Somatic ☐ Paranoia ☐ Religious	☐ Euthymic ☐ Depressed ☐ Elevated ☐ Neutral ☐ Anxious ☐ Irritable ☐ Labile ☐ Calm	☐ Appropriate ☐ Flat ☐ Blunted ☐ Constricted ☐ Incongruent w/Mood	☐ Not Present ☐ Suicidal ☐ Homicidal ☐ Assaultive ☐ Self Injurious	☐ AIMS Completed Score:________ ☐ N/A

Comments: ____________________

A (ASSESSMENT):

Health Changes	Lab/Test Results	Med Compliance	Side Effects
☐ None ☐ Note Significant Changes	☐ No New Results ☐ New Results Reviewed ☐ Lab(s) Ordered	☐ Yes ☐ No ☐ N/A	☐ Present (Please Note) ☐ Absent ☐ N/A

***Overall Rating*:**

☐ Progress ☐ Stable/Maintaining ☐ No Progress ☐ Decompensation

Comments: ____________________

LEVEL OF FUNCTIONING:

Hygiene	**Daily Tasks**	**Relationship**
☐ Independent ☐ Declining ☐ Monitoring or direction required ☐ Only with frequent prompts ☐ Unable w/out assistance	☐ Independent ☐ Declining ☐ Monitoring or direction required ☐ Requires constant prompts ☐ Unable w/out assistance	☐ Maintains social contacts ☐ Social interaction minimal ☐ Non-verbal ☐ Requires constant prompts ☐ Unable w/out assistance

Comments: ____________________

P (PLAN/INTERVENTION):

☐ Continue Medication Unchanged ☐ Treatment Plan Development/Revision ☐ Changes in Current Medications (Specify) ____________________ ☐ Risks/Benefits, Side Effects, and Alternatives were Discussed ☐ Terminate Psychiatric Services	
Referral:	
Return:	
Specify Other Interventions (as needed):	

____________________ Signature

____________________ Date

TENNESSEE DEPARTMENT OF CORRECTION
MENTAL HEALTH SERVICES
INDIVIDUAL/GROUP THERAPY SESSION – PROGRESS RECORD
PSYCHOLOGY SERVICES

Institution: ______________________

NAME: ______________________ **TDOC ID:** ______________________

DATE: ______________________ **TIME:** ______________________

S = SUBJECTIVE **O** = OBJECTIVE **A** = ASSESSMENT **P** = PLAN

☐ **Individual** ☐ **Group Type:** **Length of Session** ☐ **20-30 Min** ☐ **45-50 Min** ☐ **Other** ________

S (SUBJECTIVE): SPMI ☐ YES SMI ☐ YES DIAGNOSIS:

O (OBJECTIVE): Orientation	Memory	Speech	Thought Processes	Sleep	Hallucinations	Eye Contact
☐ O X 4 ☐ Not Person ☐ Not Place ☐ Not Time ☐ Not Situation ☐ Other	☐ Intact ☐ Memory Deficit	☐ Appropriate ☐ Rapid ☐ Pressured ☐ Slowed ☐ Mute ☐ Tangential ☐ Perseverating	☐ Appropriate ☐ Loose Assoc ☐ Flight of Ideas	☐ No Complaint ☐ Hypersomnia ☐ Insomnia ☐ Nightmares ☐ Changes in sleep pattern	☐ Not Present ☐ Tactile ☐ Olfactory ☐ Gustatory ☐ Auditory ☐ Visual	☐ Good ☐ Fair ☐ Poor

Comments: ______________________

Delusions	Mood	Affect	Danger to Self or Others	Judgement	Insight
☐ Not Present ☐ Grandiose ☐ Persecution ☐ Somatic ☐ Paranoia ☐ Religious ☐ N/A	☐ Euthymic ☐ Depressed ☐ Elevated ☐ Neutral ☐ Anxious ☐ Irritable ☐ Labile ☐ Calm	☐ Appropriate ☐ Flat ☐ Blunted ☐ Constricted ☐ Incongruent w/Mood	☐ Not Present ☐ Suicidal ☐ Homicidal ☐ Assaultive ☐ Self Injurious	☐ Good ☐ Fair ☐ Poor	☐ Good ☐ Fair ☐ Poor

Comments: ______________________

A (ASSESSMENT):

Psychiatric Medication	Medication Compliance	Group Session Level of Participation	
☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Excellent ☐ Minimal ☐ Participation with Encouragement	☐ Provided feedback to Peers ☐ Quiet but Attentive ☐ Disruptive

Number of sessions missed: ______________________

***Overall Rating*:**

☐ Progress ☐ Stable/Maintaining ☐ No Progress ☐ Decompensation

Comments: ______________________

LEVEL OF FUNCTIONING:

Hygiene	Daily Tasks	Relationship
☐ Independent ☐ Declining ☐ Monitoring or direction required ☐ Only with frequent prompts ☐ Unable w/out assistance ☐ N/A	☐ Independent ☐ Declining ☐ Monitoring or direction required ☐ Requires constant prompts ☐ Unable w/out assistance ☐ N/A	☐ Maintains social contacts ☐ Social interaction minimal ☐ Other: ________

Comments: ______________________

P (PLAN/INTERVENTION):	TREATMENT PLAN GOAL
☐ Continue with frequency/length or session ☐ Reduce frequency/length or sessions ☐ Increase frequency/length or sessions	☐ Treatment Plan Development/Revision ☐ Terminate psychological services Specify Other Interventions (as needed):
Referral:	
Return:	

Signature/Stamp

TENNESSEE DEPARTMENT OF CORRECTION
MENTAL HEALTH DISCHARGE OF SERVICES SUMMARY

____
INSTITUTION

INMATE NAME: ______________________ **TDOC ID:** ______________________

S = SUBJECTIVE **O** = OBJECTIVE **A** = ASSESSMENT **P** = PLAN

DISCHARGE SUMMARY (FOR PSYCHIATRY AND PSYCHOLOGY SERVICES)

Date	Time	
		DOB: __/__/____ **AGE:** __ **DATE SERVICES BEGAN:** __/__/____ **DISCHARGE DATE:** __/__/____
		HISTORY OF CURRENT EPISODE:
		EVALUATIONS PERFORMED:
		CLINICAL COURSE:
		CONDITION UPON DISCHARGE:
		DISCHARGE DIAGNOSIS: DSM-V
		DISCHARGE AND AFTERCARE PLAN:

______________________________ ______________________________
PRINT NAME PROVIDER SIGNATURE

TENNESSEE DEPARTMENT OF CORRECTION
MENTAL HEALTH INTAKE APPRAISAL AND EVALUATION

____

INSTITUTION

NAME: ____ TDOC ID: _____________________ DATE: ____________________________

DOB: ___________________ Gender: _________ Race: ____________________ Date of TDOC Arrival:___________________

I. BEHAVIORAL OBSERVATION / MENTAL STATUS

☐ INITIAL EVAL ☐ UPDATED EVAL ☐ DATE OF INITIAL EVAL___________________

Mood & Affect	Thought Content	Orientation	Memory	Judgment & Insight	General Appearance	Speech	
☐ Appropriate	☐ Normal/Appropriate	☐ Oriented X1, 2, 3, 4 ________	☐ Intact	**JUDGMENT**	☐ Neat	☐ Normal	☐ Appropriate
☐ Incongruent	☐ Poor Focus/Inattentive		☐ Impaired	☐ Good	☐ Unclean	☐ Hesitant	☐ Slowed
☐ Flat Affect	☐ Negative/Pessimistic		☐ Immediate	☐ Fair	☐ Bizarre	☐ Low/Quiet	☐ Mumbling
☐ Sad Mood	☐ Indecisive/Confused		☐ Recent	☐ Poor	☐ Disheveled	☐ Mute	☐ Loud
☐ Hopeless	☐ Paranoid/Suspicious	☐ Disoriented	☐ Remote			☐ Circumstantial	☐ Tangential
☐ Anxiety/Panic	☐ Loose Assoc	☐ Person	☐ Confabulations			☐ Rambling	☐ Slurred
☐ Manic	☐ Flight of Ideas	☐ Time		**INSIGHT**	**EYE CONTACT**	☐ Perseverating	☐ Rapid
☐ Labile/Swings	☐ Racing Thoughts	☐ Place	Loss specific to			☐ Flight of Ideas	☐ Pressured
☐ Euphoric	☐ Expansive	☐ Situation	☐ Trauma	☐ Good	☐ Good	☐ Threatening	☐ Angry
☐ Impulsive	☐ Suicidal/Self-Harm		☐ TBI / Stroke	☐ Fair	☐ Fair	☐ Other ____________________	
☐ Hostile	☐ Homicidal/Assaultive		☐ Other ______	☐ Poor	☐ Poor		

Observations/Comments: ☐ Cooperative ☐ Pleasant ☐ Reluctant ☐ Withdrawn ☐ Uncooperative ☐ Bizarre Behavior: _________

____
____
____

II. EDUCATION HISTORY

High School: ☐ Highest Grade Completed: ________ ☐ GED ☐ High School Diploma ☐ Enrolled in Special Ed Classes ☐ Special Ed Diploma

College/Vocational: Years Completed: ___________ Area of Study: ___________________________ Degree Received: ________________________

Comments: ____

III. WORK HISTORY

☐ Never Worked ☐ Years of Military Service:_____ ☐ Deployed in Combat Zone ☐ Receiving Disability Prior to Incarceration for: ________________

☐ Last Job Held in Free-World: __________________________________ ☐ Longest Held Job: ____

Comments: ____

IV. FAMILY AND TRAUMA HISTORY

Parent(s) Deceased: ☐ Mother ☐ Father ☐ No, Both Living Routine contact with: ☐ Mother ☐ Father ☐ Siblings ☐ Other Family Members

Parental Divorce: ☐ No ☐ Yes: Age at time of divorce: _______ Raised by: ____ ☐ Adopted

Childhood Trauma: ☐ None ☐ Abuse/Neglect ☐ Poor/Absent Parenting ☐ Parental Death ☐ Foster Care/Group Home ☐ Arrest/Detention

Describe: ____

Family history of substance abuse: ☐ No ☐ Yes: ____

Family history of mental health problems/treatment: ☐ No ☐ If yes, who: ____

Describe issues/treatment: ____

Trauma as adult: ☐ No ☐ Yes: ____

Comments:____

V. SIGNIFICANT OTHER, CHILDREN AND SOCIAL SUPPORT

Currently Married/Significant Other: ☐ No ☐ Yes, Supportive Relationship ☐ YES, BUT: ☐ Estranged ☐ No Contact ☐ Divorcing/Separating

Prior Marriages/Divorces: ☐ No ☐ Yes, #: _______ Children: ☐ No ☐ If yes, # and ages: ____

Custody of children: ☐ No ☐ Yes ☐ N/A Contact Frequency with Children: ☐ None ☐ Minimal ☐ Occasional ☐ Frequent ☐ Visitation

Caregiver to Children: ☐ No ☐ Yes Permanent Loss of Custody to: ☐ Custodial Parent ☐ Adoption ☐ Foster Care ☐ Relative ☐ Other

NAME: ______________________________ **TDOC ID:** ____________ **DATE:** ______________

Supportive family members you feel closest to NOW: ______________________________

Support System: ☐ Spouse/Partner ☐ Family ☐ Friends ☐ Describe contact: ______________________________

Recent Loss/Stressors:______________________________Comments: ______________________________

____

VI. SUBSTANCE USE HISTORY & TREATMENT

☐ Inmate Denies Prior Substance Use/Abuse Issues

Name of Substance	Use Frequency	Abuse	Dependence	First Use	Last Use	While Incarcerated?
Opioids:		☐	☐			☐ No ☐ Yes
Stimulants:		☐	☐			☐ No ☐ Yes
Cannabis/THC:		☐	☐			☐ No ☐ Yes
ETOH:		☐	☐			☐ No ☐ Yes
Hallucinogens:		☐	☐			☐ No ☐ Yes
Inhalants:		☐	☐			☐ No ☐ Yes
Sedative/Hypnotic/Anxiolytic:		☐	☐			☐ No ☐ Yes
Other:		☐	☐			☐ No ☐ Yes

Substance Use Treatment: ☐ None ☐ Yes, Outpatient (#_____) ☐ Yes, Inpatient (#_____) How many completed: ______________

Age of First Treatment: ______ Age of Last Treatment: ______ Comments:______________________________

How many prior overdoses with medical attention needed: ______ How many medical hospitalizations due to substance use: ____________

Comments: ____

____

VII. CRIMINAL HISTORY AND ASSAULTIVE/VIOLENT BEHAVIORS

Violence: ☐ Yes, Last Date: ____________ ☐ No History

Current conviction(s): ______________________________ Sentence (Yrs): __________ @__________%

Responsibility: ☐ Admits ☐ Denies ☐ Shows Remorse ☐ Victim Stance: ______________________________

Juvenile convictions: ____

Physical Assault: ☐ Without weapon ☐ With weapon Sexual Assault: ☐ Adult victim ☐ Child victim (Age_______) ☐ Both Child & Adult

Terroristic threats or acts: ☐ No ☐ Yes / ☐ Homicide, manslaughter or other assault resulting in victim's death: ______________

History Supports Potential for Violence: ☐ No ☐ Yes ☐ Noted Antisocial Traits Adjustment to Incarceration: ☐ WNL ☐ Fair ☐ Poor ☐ Needs Help

Comments:____ Prior Adjustment: ☐ WNL ☐ Fair ☐ Poor

VIII. MEDICAL CONCERNS

☐ No Reported Medical Concerns

Seizures: ☐ No ☐ Yes ☐ On Anticonvulsive Meds Head Trauma: ☐ No ☐ Yes, with loss of consciousness ☐ Yes, but no loss of consciousness

☐ General Medical Conditions:____

☐ Current Pregnancy ____ Wks Other Medical Concerns: ______________________________

☐ Poor Appetite: ____________ ☐ Weight Loss: ____________ ☐ Eating Disorder: ____________ ☐ Sleep Deficits: ______________

Past Surgeries/Other Comments: ____

____

IX. SUICIDAL IDEATION AND SUICIDE ATTEMPTS

Last suicide attempt: ☐ Never Age:_________ Method: ______________________________ Medical attention needed: ☐ Yes ☐ No

Number of prior suicide attempts: ____________ Method(s): ______________________________ Medical attention needed: ☐ Yes ☐ No

Identified triggers for suicidal thoughts/behaviors: ____

Suicide attempts while incarcerated? ☐ No ☐ Yes: ______________ Suicide attempts while intoxicated/high? ☐ No ☐ Yes ______________

History supports suicide potential: ☐ No ☐ Yes ☐ Immediate need for suicide risk assessment: ☐ MH provider and security notified

Comments: ____

____ ☐ Place on Clinical Alert Log

NAME: ______________________________ TDOC ID: ______________ DATE: ________________

X. NON-SUICIDAL SELF-INJURIOUS BEHAVIOR (NSSIB)

Last self-injury episode: ☐ Never Age:_________ Method: ____________________________ Medical attention needed: ☐ Yes ☐ No

Type of NSSIB: ☐ Cutting ☐ Head Banging ☐ Non-Cosmetic Burning ☐ Self-Mutilation ☐ Object Insertion ☐ Other: ________________

NSSIB while incarcerated? ☐ Yes ☐ No NSSIB while intoxicated or high? ☐ Yes ☐ No ☐ Placed on High Risk Log

Comments:____

____

XI. MENTAL HEALTH TREATMENT HISTORY

☐ Records Available ☐ Records Not Available ☐ Records Requested

OUTPATIENT TREATMENT **☐ No History of Outpatient Treatment**

Last outpatient treatment: ☐ Never Age:________ # of Sessions: ___________ Reason for treatment: ____________________

Prior outpatient treatment: ☐ Never Age:________ # of Sessions: ___________ Reason for treatment: ____________________

Prior outpatient facilities: ____

Prior diagnoses: ____

Comments:____

____

INPATIENT TREATMENT **☐ History of Hospitalization Related to Suicide Threat** **☐ No History of Inpatient Treatment**

Last inpatient treatment: ☐ Never Age:_________ How long: ______________ Reason hospitalized: ____________________

Last inpatient facility: ______________________________ Number of inpatient stays: ______ Longest stay: _______________

Working diagnoses: ____

Age of 1st Psychiatric Hospitalization: _________ Age of Last Psychiatric Hospitalization_________ Age of longest treatment duration:___________

Comments:____

____

PSYCHOTROPIC MEDICATIONS **☐ No History of Psychotropic Medications**

Current medications (or within last 2-4 weeks): ____ ☐ None

____

☐ Yes, prescribed in county jail ☐ Date last dose received: ____________________ Generally med compliant? ☐ Yes ☐ No

Current meds intended to treat: ____

Psychotropic meds previously prescribed: ____ ☐ None

____ ☐ AIMS Completed

Treatment Compliance: ☐ Always ☐ Usually ☐ Sometimes ☐ Infrequently ☐ Primarily When Incarcerated ☐ Likely Confounded with Substance Use

Age first prescribed meds: _______ Age last prescribed meds: _______ ☐ Arrived on meds Allergies: ____________________

____

____

XII. MENTAL HEALTH DIAGNOSTIC CHECKLIST

(To be completed by a licensed mental health professional only)

SYMPTOMS CONSISTENT WITH ANXIETY, PHOBIAS, OBSESSIVENESS & TRAUMA			
☐ Poor Focus / Concentration	☐ Obsessive Behaviors / Thoughts	☐ Flashbacks or Dissociation	☐ Mental Confusion / Amnesia
☐ Anxiety / Excessive Worry	☐ Noted CNS Hyperarousal	☐ Sleep: Insomnia / Hypersomnia	☐ Social Avoidance / Withdrawal
☐ Panic Attacks	☐ Jumpy / Easily Started	☐ Elevated Noise Sensitivity	☐ Inability to Trust Others
☐ Excessive Fear or Phobias	☐ Nightmares or Night Terrors	☐ Elevated Touch Sensitivity	☐ Paranoid / Suspicious
MOOD-RELATED SYMPTOMS, BEHAVIORAL PROBLEMS & SUICIDALITY/SELF-INJURY			
☐ Chronic Irritability	☐ Loss of Interest in Activities	☐ High Impulsivity	☐ Prior Suicidal Ideation
☐ Angry Outbursts	☐ Poor / Inconsistent ADL's	☐ Chronic Relationship Losses	☐ Prior Suicide Attempts
☐ High Hostility / Aggression	☐ Mood Swings / Lability	☐ Gross Social Deficits	☐ Borderline PD Traits
☐ Sadness / Depression	☐ Manic / Hypo-Manic Symptoms	☐ Suspected Cognitive Deficits	☐ Antisocial PD Traits
☐ Fatigue / Lethargy	☐ Racing Thoughts	☐ Self-Injury / Self-Mutilation	☐ Highly Dangerous / Homicidal

NAME: ____ **TDOC ID:** ____________________ **DATE:** ________________

AUDITORY / VISUAL HALLUCINATIONS & DELUSIONS			
☐ **Delusions**: ☐ N/A ☐ Grandiose ☐ Persecutory ☐ Religious ☐ Somatic ☐ Other: ____________________	☐ **Visual Hallucinations**: ☐ N/A ______________________________ ______________________________	☐ **Auditory Hallucinations**: ☐ N/A ______________________________ ______________________________ Type→	☐ Olfactory ☐ Hostile ☐ Tactile ☐ Demeaning ☐ Threatening ☐ Accusing ☐ Commands to hurt: __Self __Others

OTHER SYMPTOMS & STRESSORS			
☐ Poor appetite ☐ Weight Loss ☐ Eating Disorder	☐ Bizarre Behavior ☐ Fecal / Blood Smearing ☐ Suspected Gender Dysphoria	☐ Stress: Health Concerns ☐ Stress: Family Concerns ☐ Stress: Recent Losses	☐ Stress: Current/Future Sentencing ☐ Other: ________________________ ________________________________

Comments: ____

____

____

XIII. DIAGNOSTIC IMPRESSIONS (DSM-5):

(To be completed by a licensed mental health professional only)

F-CODE	COMPLETE DIAGNOSTIC LABEL	MODIFIERS
F	1.	
F	2.	
F	3.	
F	4.	
F	5.	
F	6.	
F	7.	
F	8.	

Comments: ____

____

____

Rule-out diagnoses to be considered by treating provider(s) and therapist during ongoing treatment: ______________________________

____

Additional comments/concerns/observations (continued from prior pages): ____________________________________

____

____

____

XIV. MENTAL HEALTH TREATMENT RECOMMENDATIONS

☐ No mental health treatment/treatment plan currently indicated (based on presenting symptoms).

☐ Inmate refusing mental health services due to: ____

____

☐ Pharmacotherapy indicated and referral placed. –OR— ☐ Psychotropics prescribed: ____________________

____

☐ Inmate referred for psychotherapy: ☐ Individual ☐ Group ☐ TCOM ☐ GRTH ☐ TC/PC ☐ Veteran's ☐ SLU ☐ Other: ______________

☐ Level of care of assigned: ☐ I ☐ II ☐ III ☐ IV ☐ V (Immediate placement on Suicide Precaution/Mental Health Seclusion)

☐ Inmate referred to medical for: ____

☐ Other recommendations/considerations: ____

____

______________________	______________________	__________	__________
Qualified Mental Health Provider (Completing Sections I – XI Only)	Staff Title	Date	Time
______________________	______________________	__________	__________
Licensed Mental Health Signature	Staff Title	Date	Time

TENNESSEE DEPARTMENT OF CORRECTION
MENTAL HEALTH TREATMENT PLAN REVIEW

INSTITUTION: ______________________

INMATE: ______________________

TDOC ID: ______________________

DATE OF BIRTH: ______________________

GENDER: __________

TREATMENT PLAN REVIEW DUE ON: __________

☐ VOLUNTARY ☐ INVOLUNTARY ☐ LEVEL OF CARE

☐ INPATIENT ☐ OUTPATIENT

SPECIAL UNIT: SPECIFY: __________

LEVEL OF CARE: ☐ II ☐ III ☐ IV ☐ V

DSM-5 DIAGNOSIS:

____

____

____

____

____

____

TARGET SYMPTOMS/PROBLEMS:

1) ☐ **SAME** ☐ **REVISED** __________

2) ☐ **SAME** ☐ **REVISED** __________

3) ☐ **SAME** ☐ **REVISED** __________

4) ☐ **SAME** ☐ **REVISED** __________

5) ☐ **SAME** ☐ **REVISED** __________

PROGRESS ACCORDING TO TREATMENT PLAN GOALS:

1) ☐ **NONE** ☐ **MINIMAL** ☐ **IMPROVED** ☐ **DISCHARGE GOAL** __________

2) ☐ **NONE** ☐ **MINIMAL** ☐ **IMPROVED** ☐ **DISCHARGE GOAL** __________

3) ☐ **NONE** ☐ **MINIMAL** ☐ **IMPROVED** ☐ **DISCHARGE GOAL** __________

4) ☐ **NONE** ☐ **MINIMAL** ☐ **IMPROVED** ☐ **DISCHARGE GOAL** __________

5) ☐ **NONE** ☐ **MINIMAL** ☐ **IMPROVED** ☐ **DISCHARGE GOAL** __________

NEW/REVISED TREATMENT MODALITY AND FREQUENCY:

____

____

____

____

INMATE SIGNATURE / CONSERVATOR SIGNATURE ______________ DATE __________

STAFF SIGNATURE ______________ TITLE ______________ DATE __________

STAFF SIGNATURE ______________ TITLE ______________ DATE __________

RECEIVING PROVIDER ______________ DATE __________