ADMINISTRATIVE POLICIES AND PROCEDURES State of Tennessee Department of Correction	Index #: 113.82	Page 1 of 9
	Effective Date: July 1, 2021	
	Distribution: A	
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Approved by: Tony Parker		
Subject: MENTAL HEALTH REFERRAL TRIAGE PROCESS		

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

II. PURPOSE: To ensure, upon referral, that an inmate's mental health needs are addressed in a timely manner by the most qualified mental health professional within a given institution.

III. APPLICATION: All Tennessee Department of Correction (TDOC) institutional employees, contractors, and privately managed facilities.

IV. DEFINITIONS:

A. Comprehensive Mental Health Sites: An institution designated to provide mental health services, including onsite psychiatric services for Mental Health Levels of Care II through V.

B. Emergency Referral: Referral of an inmate who requires immediate response due to a psychiatric emergency.

C. Intake Referral: A referral generated in which the inmate/staff is requesting that an inmate be evaluated for behavioral health services, and that is not currently active on the mental health caseload.

D. Licensed Independent Mental Health Professional (LIMHP): A licensed psychiatrist, advanced practice nurse (APN), a psychologist with health service provider designation, senior psychological examiner, licensed clinical social worker, or licensed professional counselor with mental health services provider designation. These individuals shall meet all educational competency and licensure/certification criteria mandated by their regulatory boards.

E. Medication Adherence Referral: A referral made by nursing staff after an inmate has refused and/or been absent for their psychotropic medication.

F. Mental Health Referral Triage Process: A procedure established to determine the mental health needs of an inmate as determined by a mental health professional(s). Upon determination of appropriate clinical need, disposition for mental health intervention is provided.

G. Non-Comprehensive Mental Health Sites: An institution designated primarily as a Level I facility, which is equipped to provide telehealth psychiatry services for inmates assigned to that institution, who may, from time to time, require psychiatric consultation.

H. PREA Screening Referral: A referral generated by TDOC counseling staff after the inmate has received a PREA screening or rescreening in accordance with policy 502.06.1.

I. Psychiatric Emergency: A sudden serious disturbance of a behavior, affect, or thought process due to an apparent mental illness that requires immediate mental health treatment intervention in order to prevent further physical or cognitive harm to an inmate or others.

J. Qualified Mental Health Professional (QMHP): For purposes of this policy, a licensed Psychological Examiner or other individual who is professionally licensed/certified as a therapeutic professional or unlicensed mental health provider having a master's degree in the behavioral sciences.

K. Routine Referrals: A referral generated by any staff member indicating that an inmate needs to be evaluated for behavioral health services that do not indicate the inmate is at acute risk for suicide or experiencing acute symptoms.

V. POLICY: All institutions shall render mental health services to inmates and shall ensure the timely response and disposition of mental health referrals.

VI. PROCEDURES:

A. The Behavioral Health Administrator shall be responsible to monitor and ensure that the behavioral health referral triage process is carried out in a timely and efficient manner. This requires a review of the reason for referral, and assignment of appropriate action, based on degrees of urgency.

B. Mental health referrals shall be handled in a timely manner. The Behavioral Health Administrator, or designee, at each institution shall review all behavioral health referrals and determine the appropriate course of action. A designee must be a qualified mental health professional or licensed independent mental health professional. The review for routine, medication adherence, PREA classification referrals, or non-urgent referrals, may consist of but is not limited to scheduling a follow-up appointment, review of the health record, OMS review, Treatment Team review, and/or face to face assessment. Urgent referrals shall be triaged in person within seven days of the referral. Treatment plans shall be developed in accordance with Policy #113.83.

C. The Licensed Independent Mental Health Professional or qualified mental health professional shall routinely serve as the screening mechanism for all referrals determined to need a face-to-face assessment (urgent referral). At non-comprehensive mental health sites or at the time of inmate transfer, medical staff may serve as the primary mechanism for referral screening.

D. Each institution shall develop a procedure to ensure that mental health staff are informed within 24 hours of an inmate's transfer to segregation. The mental health staff shall provide assessments according to Policy #113.84.

E. Referrals shall be made using Institutional Mental Health Services Referral, CR-3431.

1. The following information shall be documented by the referring health professional:

a. Reason for referral

b. Significant, acute or chronic mental/physical problems - if known

c. Referral disposition, pertinent information, or outcomes

2. The CR-3431 is maintained in the Mental Health section of the inmate's health care record.

3. Inpatient units and Supportive Living Units are not required to utilize CR-3431, unless the requested consult is not routinely provided within the confines of the treatment unit.

F. The categories of referrals include intake, routine, and emergency referrals. Emergency referrals shall be handled in accordance with Policy #113.89.

1. Intake Referrals

a. The initial TDOC Health Questionnaire, CR-2178, shall be completed immediately upon arrival by intake nursing personnel. Referrals based on the CR-2178 shall be made in accordance with Policy #113.20.

b. Inmates who arrive at the reception center who are receiving psychiatric medication must be evaluated by a LIMHP for a Mental Health Intake Appraisal and Evaluation, CR-4180, within seven days of arrival at the facility and evaluated by the psychiatrist/APN within 14 days of arrival at the facility.

c. If the decision is made to continue treatment, then treatment shall be implemented in accordance with Policy #113.83. All TDOC Mental Health

d. If the decision is made to discontinue treatment, then the psychiatrist/APN shall document the rationale on Individual Psychiatry Session-Progress Record, CR-3763.

e. Intake Appraisal and Evaluation, CR-4180, shall be completed by a LIMHP or QMHP within 14 days of receipt of referral.

2. Routine Referrals: Routine requests for mental health services are reviewed by the Behavioral Health Administrator, an Independent Licensed Mental Health Professional or qualified mental health professional as soon as possible but within seven days of the receipt of the referral by behavioral health staff. If the inmate needs further evaluation, that evaluation, by a LIMHP or QMHP, shall be completed within seven days of the mental health review. Other types of referrals that fall under this category are as follows:

a. Medication adherence referrals

b. PREA screening referrals

3. Emergency Referrals: All emergency referrals shall be handled in accordance with Policy #113.89. Institutional policies and/or procedures shall be developed to include the following requirements:

   a. Transfer: Following consultation with the psychiatrist/APN, inmates who are determined as being in crisis and are designated as Mental Health Level of Care V may be transferred to a designated Level V facility or infirmary bed. Transfers are made in accordance with Policy #113.89.

   b. Emergency Response Education/Training: All institutional staff shall receive training in mental health emergencies. Training shall be part of orientation and the institutional core curriculum and shall include:

      1. Recognition of signs and symptoms of acute mental distress and knowledge of action required in potential emergency situations

      2. Methods of obtaining assistance

      3. Signs and symptoms of mental illness, intellectual disability, and chemical dependency

      4. Suicide prevention

      5. Procedures for the transfer of inmates to a Level V bed or Level V unit at a different facility if the current facility is unable to provide such services.

   c. Procedures: Institutional policies and/or procedures shall be developed to include a written plan which covers the provision of 24-hour mental health care availability. The plan shall include arrangements for the following:

      1. Coordination of onsite emergency response and crisis intervention

      2. On-call procedures during regular business hours

      3. On-call procedures after hours and on weekends

VII. ACA STANDARDS: 5-ACI-6A-03, 5-ACI-6A-08, 5-ACI-6A-33, 5-ACI-6B-08, and 5-ACI-4A-01.

VIII. EXPIRATION DATE: July 1, 2024

TENNESSEE DEPARTMENT OF CORRECTION
HEALTH QUESTIONNAIRE

INMATE NAME: _____ TDOC ID _____ DOB _____

RECEIVING INSTITUTION: _____ DATE: ____/____/_____ TIME: _____ a.m./p.m.

INITIAL INTAKE: _____ TEMPORARY TRANSFER: _____ PERMANENT TRANSFER: _____

INQUIRE:

1. Do you have any barriers to learning? ☐ Vision ☐ Hearing ☐ Reading ☐ Writing ☐ None
2. Do you speak/read English? Speak: ☐ Yes ☐ No Read: ☐ Yes ☐ No
3.. Have you ever had a positive TB test? ☐ Yes ☐ No If **yes**, describe _____
4. Are you being treated for any illness or health problem (*including dental, venereal disease, or other infectious diseases*)?
   ☐ Yes ☐ No If **yes**, describe: _____
5. Do you have any physical, mental or dental complaints at this time? ☐ Yes ☐ No
   If **yes**, describe: _____
6. Are you currently taking any medication(s)? ☐ Yes ☐ No
   If **yes**, was the medication transferred with the inmate? ☐ Yes ☐ No
   If **yes**, describe (what used, how much, how often, date of last use, and any problems)
7. Have you recently or in the past, abused alcohol or other drugs, including prescription drugs? ☐ Yes ☐ No
   If yes, What? _____ How much? _____
8. Have you ever been hospitalized for using alcohol or other drugs, including prescription drugs? ☐ Yes ☐ No
   If **yes**, when? _____
9. Do you have any allergies? ☐ Yes ☐ No If **yes**, describe: _____

(For women)

10. a) LMP _____ b) Are you pregnant? ☐ Yes ☐ No Number of months _____
    c) Have you recently delivered? ☐ Yes ☐ No Date: _____
    d) Are you on birth control pills? ☐ Yes ☐ No
    e) Any gynecological problems? ☐ Yes ☐ No
11. Screening for MRSA Infections:
    a) Do you have any lesions, sores or insect bites? ☐ Yes ☐ No
    If **so**, do you have any open/draining lesions, sores, or insect bites? ☐ Yes ☐ No
    If **yes**, where are these lesions? _____

OBSERVE:

1. Behavior (including state of awareness, mental status, appearance, conduct, tremor and sweating):
   ☐ Normal ☐ Abnormal If **abnormal**, describe: _____
2. Skin Assessment (*including needle marks, trauma markings, bruises, lesions, jaundice, rashes, tattoos, and infestation(s)*
   ☐Yes ☐ No
   If **yes**, describe: _____
3. Is there evidence of Abuse or Trauma? ☐ Yes ☐ No If yes, describe: _____

TENNESSEE DEPARTMENT OF CORRECTION
HEALTH QUESTIONNAIRE

MENTAL HEALTH:

1. Is the inmate presenting behavior(s) that are considered: ☐ Anxious ☐ Antagonistic/Hostile ☐ Hallucinations ☐ Withdrawn/Avoidant ☐ Depressed/Hopeless ☐ No
2. Is the inmate presenting disorganized thought? (*Unable to track questions and/or present responses in logical or connected manner*) ☐ Yes ☐ No
3. Have you ever been in a mental hospital? ☐ Yes ☐ No
   If **yes**, when? _____ How often? _____
4. Have you ever been treated for mental health? ☐ Yes ☐ No
   Have you ever been treated for substance use? ☐ Yes ☐ No
5. Have you ever attempted to kill yourself? ☐ Yes ☐ No If **yes**, when? _____
   How? _____ How many times? _____
6. Are you thinking about suicide now? ☐ Yes ☐ No
   If yes, do you have a plan? ☐ Yes ☐ No
7. Has a parent, other family member, or close friend committed suicide? ☐ Yes ☐ No If **yes**, who? _____
8.. Do you have a history of past or current head trauma? ☐ Yes ☐ No If **yes**, explain type of injury: _____
   _____
9.. As an adult or child, have you personally experienced being: ☐ Sexually abused ☐ Physically abused ☐ Emotionally abused
   ☐Yes ☐ No ☐Yes ☐ No ☐Yes ☐ No
   When? (year) and by whom? _____

DISPOSITION:

_____ Intake housing _____ Intake housing with prompt referral appointment *(health, mental health, substance use treatment)*

_____ General housing _____ General housing with prompt/referral appointment

Referred to appropriate health, mental health or substance use provider ☐ Yes ☐ No

Contacted appropriate health, mental health, or substance use provider due to emergency ☐ Yes ☐ No

Additional comments on Progress Notes (CR-1884): ☐ Yes ☐ No

I have received information regarding the procedure for obtaining routine and emergency health care (*medical, dental, substance use, and/or mental health, prenatal and postpartum care for females, and co-pay requirements*). These have been explained to me and I understand how to access healthcare services in the form of:

☐ **Orientation Handbook (i.e. Inmate Handbook)**
☐ **Transient inmate information-describing how to access healthcare**
☐ **Females only: I have received the handout entitled "Disclosures Required by TCA 41-21-204**

_____
Inmate Signature

_____
Employee Name Printed

_____
Employee Signature and Title

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

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