ADMINISTRATIVE POLICIES AND PROCEDURES State of Tennessee Department of Correction	Index #: 113.83	Page 1 of 9
	Effective Date: March 15, 2020	
	Distribution: A	
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Approved by: Tony Parker		
Subject: MENTAL HEALTH EVALUATION AND MENTAL HEALTH TREATMENT PLAN		

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

II. PURPOSE: To provide guidelines for the mental health evaluation process and treatment plan and to define the contract agreement between inmates and provider(s) regarding mental health clinical services.

III. APPLICATION: All Tennessee Department of Correction (TDOC) personnel to include mental health and physical health care providers, contractors, and privately managed institutions.

IV. DEFINITIONS:

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

B. Mental Health Intake Appraisal and Evaluation (CR-4180): A structured compilation of pertinent clinical, medical, and historical background demographics related to a specific inmate, which shall include, but not be limited to, treatment recommendation(s) and diagnostic impression(s).

C. Mental Health Treatment Plan (CR-3326): An individualized document that defines the contract/agreement between the inmate and treatment provider(s) regarding mental health services. A treatment plan is based upon the assessment of an inmate's mental health needs.

D. Mental Health Treatment Plan Review (CR-3767): A clinical addendum to the most recent mental health treatment plan which documents progress and revisions of initial treatment goals.

E. Qualified Mental Health Professional: For purposes of this policy, a licensed psychological examiner or other individual who is professionally licensed/certified as a therapeutic professional or a mental health professional having a master's degree in the behavioral sciences.

V. POLICY: A mental health evaluation/update and a mental health treatment plan/treatment plan review shall be completed to assist in making a disposition for treatment services for inmates identified as requiring mental health intervention.

VI. PROCEDURES:

A. Mental Health Evaluation

1. The licensed independent mental health professional (See Policy #113.88) is responsible for assessing the inmate's clinical needs and completing the Mental Health Intake Appraisal and Evaluation, CR-4180. Other licensed/qualified mental health professionals (See Policy #113.88) may initiate or contribute to the development of the mental health evaluation or update.

2. The initial Mental Health Intake Appraisal and Evaluation, CR-4180, shall be completed on those inmates who have not received prior institutional mental health treatment or whose treatment has been discontinued and the provider has no access to the most recent mental health evaluation.

3. A Mental Health Intake Appraisal and Evaluation, CR-4180, shall be considered an update when the most recent mental health evaluation is available to the treatment provider and:

   a. There is a significant change in diagnosis or

   b. The inmate has received prior institutional mental health treatment but none for the preceding 12 months.

   c. Intake evaluations shall require that the inmate be triaged by a QMHP or the LIMHP. If a psychiatric referral is necessary, it must be completed within seven days of triage.

   d. When a Level of Care (LOC) 1 is released from suicide precautions/mental health seclusion, the psychiatric provider will determine if a LOC change is warranted. If the inmate's LOC is raised, then the CR-4180 shall be completed by a licensed mental health professional within 72 hours.

4. Routine mental health referrals shall require that a Mental Health Intake Appraisal and Evaluation, CR-4180, be completed within 14 days from the time the inmate has been identified as requiring a mental health intervention and the referral has been received by mental health.

5. For all inmates determined to be in need of any mental health services, recent mental health treatment records will be routinely requested after obtaining the consent of the inmate. It is the responsibility of the evaluator to get appropriate Authorization for Release of Health Services Information, CR-1885, signed at the time of the evaluation so all records needed may be requested. A copy of the form will be filed in the Health Record Section 10.

6. Inmates requesting and determined to be in need of mental health services will be referred to treatment opportunities as indicated by the inmate's diagnosis. Individual and group treatment services will be documented on the mental health treatment plan and updated on the mental health progress note.

7. The inmate's level of care designation shall be assigned at the conclusion of the mental health evaluation. The level of care (LOC) or changes to LOC can only be assigned by a psychiatric provider or psychologist with health services provider designation. The level of care assigned shall be entered in the offender management system (OMS) Mental Health Screen LHSM and on the Health Services Major Medical Conditions Problem List, CR-1894. (See #113.89 for form sample)

B. Mental Health Treatment Plan

1. Except in circumstances of involuntary treatment rendered in accordance with Policy #113.89, the inmate or the inmate's healthcare agent (conservator, e.g.) shall participate in the development and review of his/her treatment plan in accordance with Policy #113.51. Consultation with the inmate's healthcare agent about the development or update of the treatment plan may occur in person, by telephone, or by mail, according to the healthcare agent's preference.

2. An individual Mental Health Treatment Plan, CR-3326, shall include a series of written statements that address key components of the inmate's mental health issues and treatment. Mental Health Treatment plans shall be developed after a Mental Health Intake Appraisal and Evaluation, CR-4180, reveals the initiation of psychological and/or psychiatric treatment.

3. A mental health treatment plan shall include, but not be limited to, the following:

   a. A diagnosis and code identified from the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM)

   b. Target symptoms and presenting problems

   c. Goals to address target symptom and presenting problems

   d. The types of therapeutic interventions and frequency that will be used to achieve those goals.

   e. Signature and title of the providers who will deliver the treatment

   f. Signature of the inmate or healthcare agent.

4. Co-signature on Mental Health Treatment Plan, CR-3326, and Mental Health Treatment Plan Review, CR-3767, by the licensed independent mental health professional is required for qualified mental health professionals who primarily develop treatment plans and treatment plan reviews. The original Mental Health Treatment Plan, CR-3326, shall be filed in the most current health record.

5. For intra-system transfers, existing treatment plans and/or treatment plan reviews shall require the signature of the new provider(s) or new plans/reviews shall be developed within 14 days of the inmate's arrival at the facility to ensure continuity of treatment.

6. At least once per quarter, the Mental Health Administrator/designee shall provide the Warden/Superintendent and the Director of Behavioral Health Services with a list of names of inmates who have active treatment plans.

7. The inmate's signature on the Informed Consent for Assessment and Treatment, CR-3766, shall signify his/her consent for mental health services by the licensed independent mental health professional and/or the qualified mental health professional.

8. The attending treatment provider shall review the mental health treatment plan periodically, with the inmate or healthcare agent, as often as may be indicated by the inmate's presentation, but no less than every six months. Such periodic review shall be documented on Mental Health Treatment Plan Review, CR-3767.

9. The most current mental health diagnosis for the patient is recorded on the Major Problem List, CR-1894.

VII. ACA STANDARDS: 4-4350, 4-4368, 4-4372, and 4-4399.

VIII. EXPIRATION DATE: March 15, 2023.

TENNESSEE DEPARTMENT OF CORRECTIONS
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 High Risk 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

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

AUTHORIZATION FOR RELEASE OF HEALTH SERVICES INFORMATION

_____
INSTITUTION

INMATE NAME (PRINTED) _____ TDOC ID_____

SOCIAL SECURITY NUMBER _____ DATE OF BIRTH _____ GENDER _____

☐ I hereby authorize _____to release the
(NAME OF PROVIDER/FACILITY)
information indicated below to the Tennessee Department of Correction (TDOC) regarding my medical treatment.

TDOC Facility Name/Community Supervision Office: _____

Facility Address: _____

Phone Number: _____ Fax Number: _____

☐ I hereby authorize the Tennessee Department of Correction to release the information indicated below to the following:

Name: _____ Relationship to Inmate: _____

Address: _____

Address 2: _____

Phone Number: _____ Fax Number: _____

Please release the following information (Check "✓" all that apply):

☐ Health Record ☐ Infectious Disease Record ☐ Dental Record ☐ Mental Health Record ☐ Psychotherapy Notes
☐ Substance Use Diagnosis/Treatment ☐ Other _____ dates ___/___/_____ through _____/____/_____

Note: An authorization for the release of psychotherapy notes cannot be made in conjunction with an authorization for the release of any other confidential health information. An authorization to release psychotherapy notes must be executed separately from any other authorization for disclosure.

- This authorization expires six (6) months from the date of the signature below and covers only information created prior to that date. I understand that I may retract this authorization at any time, in writing, to the attention of: TDOC Division of Operational Support Services. Rachel Jackson Building, 320 Sixth Avenue North, Nashville, TN 37243-0465.
- I understand that any release, which was made prior to a retraction hereof, and based on this signed authorization, will not constitute a breach of my privacy rights.
- I understand that this authorization is necessary to release information that is deemed private and confidential by law (health records, TCA 10-7-504, mental health records, TCA 33-3-103).
- I understand that a provider may not condition treatment on whether or not I sign this authorization.
- Although the recipient should obtain my authorization before releasing my private information, I understand that if the recipient chooses to re-disclose this information, TDOC cannot ensure its protection by privacy laws.

The subject of the information must sign this authorization. If the subject is under 18 years of age, it must be signed by a parent or legally appointed guardian. If the subject is not legally competent to sign, or is unable to sign, Authorized Representative (a legally appointed conservator, guardian, or attorney-in-fact appointed pursuant to a durable power of attorney for healthcare) must sign this authorization.

Inmate Signature	Date	Signature of Parent (if minor) or Authorized Representative	Date
Witness Signature	Date		

TENNESSEE DEPARTMENT OF CORRECTION
HEALTH SERVICES

MAJOR PROBLEM LIST

_____
INSTITUTION

Name: _____ TDOC ID: _____
Last First Middle

Date of Birth: _____ Gender: ☐ M ☐ F Race: _____

Allergies: _____

PROBLEM NUMBER*	DATE IDENTIFIED/ RECORDED	MAJOR CLINICAL CONDITIONS/PROBLEMS	RESOLVED *(Please check "√" if resolved)*	RESOLVE DATE

Conservator Name: _____

Primary Phone: _____ Secondary Phone: _____

* Major medical problems considered medical or surgical in nature are identified by Roman numerals, i.e., **I** – Diabetes, **II** – Laminectomy.
* Psychiatric, or serious psychological problems, are identified by capital letters, i.e., **A** – Schizophrenia, **B** – Self-Mutilative Behavior.

TENNESSEE DEPARTMENT OF CORRECTION
MENTAL HEALTH SERVICES
INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

_____
INSTITUTION

_____ _____ _____
INMATE NAME TDOC ID DATE OF BIRTH

I hereby authorize _____ to perform the following assessment or treatment:

_____

_____
Use Layman's Terms

The type and extent of services that I will receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me.

I understand that a range of mental health professionals, some of whom are in training, provides mental health services. All professionals-in-training are supervised by licensed staff.

I understand that while psychotherapy and/or medication, may provide significant benefits, it may also pose risks. If medications are prescribed, the psychiatric provider and I have discussed:

- My Mental Health Condition
- The reasons for prescribing the medication, including the likelihood of my condition
- Improving or not improving without the medicine.
- Reasonable alternative treatments available for my condition.
- The type of medication that I will be receiving, the frequency and range of dosages, the method by which I will take the medication (shots or mouth), and duration of such treatment.
- The side effects of these drugs known to commonly occur and any particular side effects likely to occur in my particular case.

Psychological Services can have benefits and risks. Since therapy often involves discussing unpleasant aspects of my life, I may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits such as significant reductions in feelings of distress.

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 intervention for the judgment of the practitioner for procedures in addition to or different from those now contemplated a new informed consent assessment and treatment will be obtained.

I have read and fully understand the terms of this consent.

Date: _____ Time: _____ _____
Signature of the inmate or person authorized to consent for inmate

_____ _____
Signature of Practitioner and Professional Title Signature of Practitioner and Professional Title

Witness: _____