INITIAL MENTAL HEALTH EVALUATION

CCS CORRECT CARE SOLUTIONS

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

Reason for Referral ❑ Referral based on Admission Screening ❑ Referral based on Initial Health Assessment ❑ Inmate Request

Reviewed Receiving Screening ❑ Yes ❑ No
Reviewed INS Screen ❑ Yes ❑ No
If No, explain: _____

Reviewed Health Assessment ❑ Yes ❑ No
Reviewed INS Screen ❑ Yes ❑ No

Allergies _____

Past History

Prior MH Treatment ❑ Outpatient ❑ Inpatient Provider? _____
ROI completed? ❑ Yes ❑ No _____

Prior MH Medication ❑ Yes ❑No If Yes, list: _____

Prior CRT Services ❑ Yes ❑No If Yes, detail: _____
Note if currently receiving: _____

Prior DAIL Services ❑ Yes ❑No If Yes, list: _____
Note if currently receiving: _____

Prior MH Court Services ❑ Yes ❑No If Yes, list: _____
Note if currently involved: _____

Prior SSDI ❑ Yes ❑No If Yes, list: _____
Note if currently receiving: _____

Prior Guardianship ❑ Yes ❑No If Yes, list: _____
Note current guardian, if any: _____

Past Self Harm ❑Yes ❑ No If Yes, detail: _____

Past History of Violent Behavior ❑ Yes ❑ No If Yes, detail: _____
Past History of Sexual Assault ❑ Yes ❑ No If Yes, detail: _____
Past History of Victimization ❑ Yes ❑ No If Yes, detail: _____
Past History of Head Injury ❑ Yes ❑ No If Yes, detail: _____
Past Substance Abuse treatment ❑ Yes ❑ No If Yes, detail: _____

Personal/Social History

Educational Hx: _____

Employment Hx: _____

Military Hx: _____

Family Support Status: _____

Legal History: _____

Housing Status: _____

Religious Preference: _____ Place of Birth: _____

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INITIAL MENTAL HEALTH EVALUATION

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

Current Status

Currently in MH Treatment ❑ Yes ❑ No Specify: _____

ROI Completed ❑ Yes ❑ No

Currently taking MH meds ❑ Yes ❑ No Provider: _____

Dose/Frequency/Date Last Taken: _____

Current Self Harm thoughts ❑ Yes ❑ No Specify: _____

Substance Use ❑ Yes ❑ No Age of first use and last use? _____

Drug of choice and amount? _____

Concerns about ability to cope while incarcerated? ❑ Yes ❑ No _____

Current MH Issues ❑ Yes ❑ No Specify: _____

What has the client attempted to address issue? _____

Note interventions/educational material provided and receptiveness of client? _____

Client Strengths: _____

Clinician Observations: _____

Mental Status Exam

Sensorium:	Behavior:	Mood:	Thought Process:	Thought Content:
❑ Alert ❑ Oriented x 3 ❑ Distractible ❑ Poor concentration ❑ Other _____	❑ Calm ❑ Agitated ❑ Slowed ❑ Other_____	❑ Euthymic ❑ Depressed ❑ Anxious ❑ Elevated ❑ Irritable ❑ Other_____	❑ Goal-Directed ❑ Disorganized ❑ Loose Associations ❑ Tangential ❑ Other_____	❑ Homicidal ❑ Suicidal ❑ Paranoid ❑ Hallucinations ❑ Delusions ❑ Other_____
Appearance:	**Speech:**	**Affect:**	**Memory:**	**Cognitive Estimate:**
❑ Well kept ❑ Self-neglect ❑ Other_____	❑ Clear/Coherent ❑ Spontaneous ❑ Pressured ❑ Poverty ❑ Other_____	❑ Appropriate ❑ Inappropriate ❑ Constricted ❑ Blunted ❑ Other_____	❑ Recent Intact ❑ Remote Intact ❑ Impaired ❑ Other_____	High ❑ Average ❑ Low

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INITIAL MENTAL HEALTH EVALUATION

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

Plan

- ❑ Refer to MH Special Needs
- ❑ Refer to Psychiatry
- ❑ Initiate Crisis Watch
- ❑ Follow up by MH on _____ (date)
- ❑ Refer to Discharge Planner
- ❑ MH follow-up PRN; inmate educated on how to request services
- ❑ Provide educational material, specify: _____
- ❑ Refer to Medical for: _____
- ❑ Other: _____

_____

Signature **Date & Time**

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Altered Mental Status

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

Date: _____ Time: _____

S: Subjective:
Performing a focused history can help rule out many causes of altered mental status. During the interview with the patient, obtain a history specifically centering on diabetes, hypoglycemia, COPD, thyroid dysfunction, kidney disease, liver disease, mental illness, seizure disorder, infection, dementia, trauma, stroke, heart disease, and drug abuse/withdrawal._____

Obtain medication history (illicit, prescription, and OTC) noting time of last dose and the amount taken: _____

Inquire as to any associated symptoms the patient is currently having (chest pain/tightness, shortness of breath, weakness, etc).

Assess overall level of consciousness:

O:
Examination:
O2 sat_____ TEMP_____ Finger-stick Glucose _____
BP_____ HR_____ (supine)
BP_____ HR_____ (standing)

Perform Six Item Screen of Confusion as follows:
1.Give the patient three items to remember (apple, table, and penny), and ask the patient to repeat them aloud.
2.Ask the patient to state the current year, month, and day of week.
3.Ask the patient to repeat the original three items.
One point is given for each correct answer.
Total score: _____ (9 max)

A score below five (5) connotes nonpsychiatric or medication-related cognitive impairment.

Obtain a dip-stick urinalysis and document below.
UA:
Specific gravity:
LE:
Nit:
Blood:
Urobil:
Protein:

Note any jaundice, pedal edema, wheezing, signs of acute infection or recent trauma, or unilateral weakness.

A: Assessment:

"Alteration in mental status" _____

P: Interventions:

- For symptomatic blood glucose of < 60, initiate appropriate nursing intervention per hypoglycemia pathway and call HCP.
- For symptomatic blood glucose of >400, call HCP for orders.
- For O2 sat<92% on room air, provide 2L O2 by facemask and call HCP.
- If fever (temperature>99.6 F) is present, then call HCP for additional orders.
- If patient exhibits any of the following:
  - Standing SBP is >20mm Hg LOWER than supine
  - Standing DBP is >10mm Hg LOWER than supine
  - Standing Heart Rate is >25bpm HIGHER than supine

  then, place patient in supine position and call HCP.
- For patients with altered mental status and a h/o substance abuse/withdrawal, call HCP for orders.
- Other- any patient exhibiting altered mental status with or without an abnormal physical exam necessitates a call to the HCP for orders.

Comments: _____

Nurse's signature and date:

Reviewer's signature and date:

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Revised 11/23/09

Informed Consent for Mental Health Treatment Services

2 Page Form

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

*****Do not sign this agreement until you have spoken to the Mental Health Professional*****

Correct Care Solutions provides counseling and other mental health services for inmates in the Vermont Department of Corrections. We want you to be fully informed about the treatment you are offered and the conditions that govern the treatment process. Please be advised that this consent does not apply when mental health services are provided to third parties, such as in the case of evaluations conducted for the Vermont Parole Board.

The Intake Interview

A mental health professional will meet with you to learn more about your current concerns. This interview will last 20-60 minutes. The mental health professional may ask you questions about any past difficulties and your current situation. The mental health professional may ask you about the reasons for your current incarceration. Please be as honest as possible and let the mental health professional know if you are uncomfortable discussing an issue. During the interview, you may also be asked to complete some questionnaires about your needs and current concerns. You may ask any questions you have about the mental health services available. Your interviewer will also inform you: (1) of the interviewer's qualifications, (2) whether the mental health professional is under supervision toward advanced licensure, and (3) that consultation with other mental health staff may occur during your treatment.

Your Health Care Record

Information obtained during your intake interview and during other meetings with mental health staff is documented in your health care record. Members of the health care staff, health care auditors and VDOC administrators have access to your health care record as the situation merits. Corrections staff are only provided access to the health record on a "need-to-know" basis.

You may request to review your health care record with a mental health professional at any time. A medical/mental health request form should be used to ask for a review. In rare circumstances, and as approved by the Regional Director of Mental Health Services, you may be denied the opportunity to review your file. You will not receive a copy of your health record.

Limits of confidentiality

Generally, all mental health therapies are treated as strictly confidential. At times there are special situations in which confidentiality will be limited. Mental health staff must report situations which could be harmful to you or others, or a threat to the orderly operation of the facility. These include but are not limited to:

1. Escape planning
2. Planned violence towards others
3. Risk of suicide or self-harm
4. Hunger strikes
5. Drug sale or use during incarceration
6. Inappropriate relationships with staff
7. Child abuse

In order to help you prepare for release, information from your health care record may be given to your parole or post-release supervisor. Information from your heath care record may be used as part of a Transfer Request (e.g., when considering transfer to the Vermont State Hospital). Outside of the issues noted above, your written permission is required before mental health staff can release information from your health record. You will be asked to sign a release of information form should you wish us to discuss your treatment with a third party, including your family members and your attorney.

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revised 05/01/2010

Informed Consent for Mental Health Treatment Services

2 Page Form

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

Mental health staff asks all clients enrolled in group therapy or psycho-educational groups to not talk to anyone else about anything said during these groups. However, we cannot guarantee that group members will respect this request. You need to be aware that confidentially leaks can happen. Clients found to be sharing information from the group with others will be removed from the group.

Your Treatment Plan

You and your mental health professional will write a treatment plan to guide your work in mental health. Treatment plans contain goals and treatment methods that will be used to help meet these goals. The treatment plan will also include your diagnosis and how long your treatment is expected to last. The treatment methods may include group therapy, short-term individual therapy, enrollment in the Special Needs program, and medications as prescribed by a qualified psychiatric provider. If you are in a special mental health unit in the VDOC, the treatment plan should also contain your requirements for moving through the treatment program.

Treatment services offered by a mental health professional have potential benefits, and in some cases, risks. Your mental health professional will talk with you about these risks and benefits before starting treatment. It is our expectation that you will carefully consider all treatment options before beginning treatment. Unless you are considered by a mental health professional to be at risk of harm to yourself or others, you may refuse mental health treatment at any time. A mental health professional will ask you to complete a refusal form should you decide to refuse treatment.

Ending Treatment

It is best that you and your mental health therapist agree on when to end treatment. Some services last for a certain number of meetings, and other services are open-ended. You will be told at the beginning of treatment when you should expect to complete the treatment. At the end of treatment, you may be asked some questions about your treatment. We want to know if you found treatment helpful and the level of satisfaction you had with the services.

Let your mental health professional know if you have concerns about your treatment or if you want to end treatment. If you are uncomfortable talking about your concerns with your mental health professional, you may contact the Regional Director of Mental Health Services to address your issues. If you cannot solve your concerns adequately with mental health staff, you are directed to the grievance procedure outlined in your Inmate Handbook.

Treatment Consent

By signing, I am indicating that I have read the information above and have been given the opportunity to ask questions. I have read about the limits of confidentiality, the disposition of my health record, and my treatment options. I am agreeing to mental health treatment under these conditions. I also understand that I may refuse in writing to participate in mental health treatment at any time, ending this agreement.

Inmate Signature **I agree to participate in treatment** _____ **I refuse to participate in treatment** _____	**Date**
Mental Health Provider Signature & Title	**Date**

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revised 05/01/2010

Psychiatric Provider
Initial Evaluation Note

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

ALLERGIES _____

Presenting Issue: _____

_____

_____

Current Medications / Side Effects: _____

Objective: Mental Status Exam

Sensorium: ❑ Alert ❑ Oriented x 3 ❑ Distractible ❑ Poor concentration ❑ Other_____

Appearance: ❑ Well kept ❑ Self-neglect ❑ Other_____

Behavior: ❑ Calm ❑ Agitated ❑ Slowed ❑ Other_____

Speech: ❑ Clear/Coherent ❑ Spontaneous ❑ Pressured ❑ Poverty ❑ Other_____

Mood: ❑ Euthymic ❑ Depressed ❑ Anxious ❑ Elevated ❑ Irritable ❑ Other_____

Affect: ❑ Appropriate ❑ Inappropriate ❑ Constricted ❑ Blunted ❑ Other_____

Thought Process: ❑ Goal-Directed ❑ Disorganized ❑ Loose Associations ❑ Tangential ❑ Other_____

Thought Content: ❑ Homicidal ❑ Suicidal ❑ Paranoid ❑ Hallucinations ❑ Delusions ❑ Other_____

Describe hallucinations/delusions: _____

Memory: ❑ Recent Intact ❑ Remote Intact ❑ Impaired ❑ Other_____

AIMS: _____Baseline Score ❑ N/A – based on current treatment regimen

Prior Self-Harm: _____

Prior Violence: _____

Relevant PMH: _____

Family Psych. Hx.: _____

Past Hospitalizations: _____

Past Meds: _____

Substance Abuse Hx.: _____

Social Hx: _____

Diagnosis:

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

Plan: 1. Medication: _____

(dose, frequency, duration)

2. Lab: _____

3. Other (include F/U by MHP): _____

4. Follow up Appt: ❑ _____week(s) ❑ PRN ❑ No f/u necessary

_____ Psychiatric Provider

_____ Date

**Additional Information on Next Page ❑ Yes ❑ No*

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Psychiatric Provider
Initial Evaluation Note

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

Psychiatric Provider

Date

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CCS-MH03
revised 12/1/09

Mental Health Services

Medication Consent Form

Non-Stimulant ADHD Agents

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

I,

agree to treatment with the following medications in the dosage recommended to me by the psychiatric provider:

( ) anti-hypertensives (e.g., clonidine, guanfacine, Tenex, Intuniv, Kapvay, etc.)

( ) Strattera

I have been made aware that the following are benefits that may occur through taking these medications:

Decreased symptoms of hyperactivity, impulsivity, incompletion of tasks, inattention, restlessness, insomnia, and difficulty organizing activities.

I have been made aware that possible side effects of taking these medications may be:

( )For anti-hypertensives:

decreased blood pressure, decreased heart rate, dizziness, sedation, sleepiness, dry mouth upper respiratory symptoms, and withdrawal symptoms including increased blood pressure / heart rate and nervousness

( )For Strattera:

constipation, nausea, sweating, decreased appetite, sexual side effects, fatigue, insomnia, and rare issues such as suicidal ideation, mania, and symptoms of liver damage

I voluntarily agree to take the medication(s) listed above as prescribed by the psychiatric provider. I understand that I may choose to withdraw this permission in the future at my discretion. I have had an opportunity to ask any questions, and I am satisfied with the explanations.

Psychiatric Provider Signature	Date	Patient's Signature	Date

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SERVICIOS DE SALUD MENTAL

CONSENTIMIENTO PARA LOS

AGENTES DE ADHD NO ESTIMULANTES

Patient Name	*Patient Number*	*Booking Number*	*Date of Birth*	*Today's Date*

Yo
estoy de acuerdo con el tratamiento de los siguientes medicamentos en la dosis recomendada para mí por el especialisto psiquiátrico.

( ) Antihipertensivos (por ejemplo, clonidina, guanfacina, Tenex, Intuniv, Kapvay, etc)

( ) Strattera

He sido informado de que los siguientes beneficios que se pudieran producir por tomar estos medicamentos:

La disminución de los síntomas de hiperactividad, impulsividad, incumplimiento de las tareas, falta de atención, inquietud, insomnio y dificultad para organizar actividades.

He sido informado de que los posibles efectos secundarios de tomar cualquiera de estos medicamentos pueden ser:

( ) Para los antihipertensivos:
disminución de la presión arterial, disminución del ritmo cardíaco, mareos, sedación, somnolencia boca seca, síntomas respiratorios superiores, y los síntomas de abstinencia, incluyendo aumento de la presión arterial / frecuencia cardíaca y el nerviosismo

( ) Strattera:
estreñimiento, náuseas, sudoración, disminución del apetito, los efectos secundarios sexuales, fatiga, insomnio y problemas poco comunes, tales como ideación suicida, la manía, y los síntomas de daño hepático

Acepto voluntariamente tomar el/los medicamento(s) que figura(n) en la forma prescrita por el proveedor psiquiátrico.Yo entiendo que puedo optar por retirar este permiso en el futuro a mi discreción. He tenido la oportunidad de hacer preguntas, y estoy satisfecho con las explicaciones.

_____ _____
Firma del Especialista Psiquiátrico Fecha Firma del Paciente Fecha

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Mental Health Services

Medication Consent Form

Stimulants

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

I,

agree to treatment with the following medications in the dosage recommended to me by the psychiatric provider:

( ) Ritalin / Ritalin SR / Ritalin LA
( ) Adderall / Adderall XR
( ) Others
( ) Vyvanse
( ) Concerta
( ) Focalin / Focalin XR

I have been made aware that the following are benefits that may occur through taking these medications:

Decreased symptoms of inattention, poor concentration, hyperactivity, impulsivity, incompletion of tasks, and difficulty organizing activities.

I have been made aware that possible side effects of taking any of these stimulant medications may be:

( ) anxiety, insomnia, agitation, nausea, decreased appetite, weight loss, headaches, palpitations, tachycardia, hypertension, psychosis, tics, tolerance, dependence, and abuse

( ) _____ _____

I voluntarily agree to take the medication(s) listed above as prescribed by the psychiatric provider. I understand that I may choose to withdraw this permission in the future at my discretion. I have had an opportunity to ask any questions, and I am satisfied with the explanations.

_____ _____ _____ _____

Psychiatric Provider Signature Date Patient's Signature Date

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SERVICIOS DE SALUD MENTAL

CONSENTIMIENTO PARA MEDICAMENTOS ESTIMULANTES

CCS CORRECT CARE SOLUTIONS

Patient Name	*Patient Number*	*Booking Number*	*Date of Birth*	*Today's Date*

Yo
estoy de acuerdo con el tratamiento de los siguientes los medicamentos en la dosis recomendada para mí por el especialisto psiquiátrico.

( ) Ritalin / Ritalin SR / Ritalin LA
( ) Adderall / Adderall XR
( ) Otros
( ) Vyvanse
( ) Concerta
( ) Focalin / Focalin XR

He sido informado de que los siguientes beneficios se pudieran producir por tomar estos medicamentos:

La disminución de los síntomas de falta de atención, falta de concentración, hiperactividad, impulsividad, incumplimiento de las tareas y dificultad para organizar actividades.

He sido informado de que los posibles efectos secundarios de tomar cualquiera de estos medicamentos estimulantes pueden ser:

( ) ansiedad, insomnio, agitación, náuseas, disminución del apetito, pérdida de peso, dolores de cabeza, palpitaciones, taquicardia, hipertensión, psicosis, tics, tolerancia, dependencia y abuso

( ) _____

Acepto voluntariamente tomar el/los medicamento(s) que figura(n) en la forma prescrita por el proveedor psiquiátrico.Yo entiendo que puedo optar por retirar este permiso en el futuro a mi discreción. He tenido la oportunidad de hacer preguntas, y estoy satisfecho con las explicaciones.

_____
Firma del Especialista Psiquiátrico Fecha

_____
Firma del Paciente Fecha

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Mental Health Services

Medication Consent Form

Anti-Anxiety

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

I,

agree to treatment with the following medications in the dosage recommended to me by the psychiatric provider:

( ) Hydroxyzine (Vistaril)
( ) Propanolol (Inderal)
( ) Buspirone (Buspar)
( ) Benzodiazepines (lorazepam, alprazolam, chlordiazepoxide)
( ) Other

I have been made aware that the following are benefits that may occur through taking these medications:

Decrease anxiety, increased sedation

I have been made aware that possible side effects of taking these medications may be:

( ) Hydroxyzine: dry mouth, sedation, priapism (priapism is a persistent and painful erection (hard penis) that lasts more than 4 hours). This is a rate but serious sexual side effect that if not treated immediately can lead to scarring and permanent erectile dysfunction (loss of sexual function). Alert medical staff immediately if you experience these symptoms.

( ) Propanolol: low blood pressure

( ) Buspirone: dizziness, insomnia, sedation, anxiety, dry mouth, priapism (priapism is a persistent and painful erection (hard penis) that lasts more than 4 hours). This is a rate but serious sexual side effect that if not treated immediately can lead to scarring and permanent erectile dysfunction (loss of sexual function). Alert medical staff immediately if you experience these symptoms.

( ) Benzodiazepines physical dependence, amnesia, withdrawal syndrome

( ) Other _____

Concurrent use of other medications may increase the risk of priapism, including typical antipsychotics; the following atypical antipsychotics: clozapine, risperidone, olanzapine, aripriprazole, quetiapinel; all classes of antidepressants, terazosin, tamsulosin, alfuzosin, prazosin, hydralazine, heparin, acenocumorol, warfarin, tadalafil, sildenafil.

I voluntarily agree to take the medication(s) listed above as prescribed by the psychiatric provider. I understand that I may choose to withdraw this permission in the future at my discretion. I have had an opportunity to ask any questions, and I am satisfied with the explanations. All the side effects listed above have been explained to me, and I understand the risks and benefits of taking this medication.

_____ _____

Psychiatric Provider Signature Date Patient's Signature Date

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SERVICIOS DE SALUD MENTAL

FORMULARIO DE CONSENTIMIENTO PARA MEDICAMENTOS

Contra la Ansiedad

CCS CORRECT CARE SOLUTIONS

Patient Name	*Patient Number*	*Booking Number*	*Date of Birth*	*Today's Date*

Yo
estoy de acuerdo con el tratamiento de los siguientes medicamentos en la dosis recomendada para mí por el especialista psiquiátrico:

( ) Hidroxizina (Vistaril) ( ) propranolol (Inderal) ( ) Buspirona (Buspar)
( ) Las benzodiacepinas (lorazepan, clordiazepóxido, alprazolam)
( ) Otro

He sido informado de que los siguientes beneficios se pudieran producir por tomar estos medicamentos:

Disminución de la ansiedad, aumento de sedación

He sido informado de que los posibles efectos secundarios de tomar estos medicamentos pueden ser:

( ) Hidroxizina: sequedad de boca, sedación, priapismo (priapismo es una erección persistente y dolorosa (pene erecto) que dura más de 4 horas).Este es un efecto sexual secundario raro pero grave que si no se trata inmediatamente pueden conducir a la cicatrización y disfunción eréctil permanente (pérdida de la función sexual).Alerte al personal médico inmediatamente si usted experimenta estos síntomas.

( ) Propanolol: presión arterial baja

( ) Buspirona: mareos, insomnia, sedación, ansiedad, boca seca, priapismo (priapismo es una erección persistente y dolorosa (pene erecto) que dura más de 4 horas).Este es un efecto sexual secundario raro pero grave que si no se trata inmediatamente pueden conducir a la cicatrización y disfunción eréctil permanente (pérdida de la función sexual).Alerte al personal médico inmediatamente si usted experimenta estos síntomas.

( ) Las benzodiazepinas: dependencia física, amnesia, síndrome de abstinencia
( ) Otro _____

El uso acompañante de otros medicamentos puede aumentar el riesgo de priapismo, incluyendo los antipsicóticos típicos, los antipsicóticos atípicos siguientes: clozapina, risperidona, olanzapina, aripriprazole, quetiapinel, todas las clases de antidepresivos, terazosina, tamsulosina, alfuzosina, prazosina, hidralazina, heparina, acenocumorol, warfarina, tadalafilo, sildenafilo.

Acepto voluntariamente tomar el/los medicamento (s) que figura(n) en la forma prescrita por el especialista psiquiátrico.Yo entiendo que puedo optar por retirar este permiso en el futuro a mi discreción.He tenido la oportunidad de hacer preguntas, y estoy satisfecho con las explicaciones.Todos los efectos secundarios mencionados anteriormente se me han explicado y entiendo los riesgos y beneficios de tomar estos medicamentos.

_____ _____
Firma del Especialista Psiquiátrico Fecha Firma del Paciente Fecha

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Mental Health Services

Medication Consent Form

Anti-depressant

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

I,
agree to treatment with the following medications in the dosage recommended to me by the psychiatric provider:

( ) Trazodone
( ) Tricyclic Antidepressant (TCA)
( ) SSRI
( ) Other
( ) Wellbutrin
( ) Mirtazapine
( ) SNRI (Effexor, Cymbalta, Pristiq)

I have been made aware that the following are benefits that may occur through taking these medications:

Decreased symptoms of depression (depressed mood, anxiety, insomnia, excess guilt, worthlessness, low energy, agitation, poor concentration), and/or symptoms of anxiety.

I have been made aware that possible side effects of taking these medications may be:

( ) All meds below	priapism (priapism is a persistent and painful erection (hard penis) that lasts more than 4 hours). This is a rare but serious sexual side effect that if not treated immediately can lead to scarring and permanent erectile dysfunction (loss of sexual function). Alert medical staff immediately if you experience these symptoms
( ) All meds below:	mania/hypomania (excessive energy), sedation, nausea/vomiting, impaired cognitive and motor functioning (racing thoughts, fatigue), sexual dysfunction (low sexual drive) anxiety, withdrawal syndrome, asthenia (loss of energy), increase in suicidal ideation
( ) Trazodone	dizziness, nausea, nasal congestion
( ) TCA	dry mouth, constipation, blurred vision, difficulty urinating, cardiac conduction defects, hypo/hypertension (low/high blood pressure), weight gain, sweating
( ) SSRI	nausea, diarrhea, headaches, anxiety, insomnia, fatigue, tremors, akathisia (restlessness)
( ) SNRI	nausea, headaches, sweating, insomnia, hypertension (not Cymbalta)
( ) Wellbutrin	headaches, nausea, anxiety, insomnia, seizures
( ) Mirtazapine	dry mouth, constipation, sedation, neutropenia, weight gain
( ) _____	_____

Concurrent use of other medications may increase the risk of priapism, including typical antipsychotics; and clozapine, risperidone, olanzapine, aripriprazole, quetiapine, terazosin, tamsulosin, alfuzosin, prazosin, hydralazine, buspirone, hydroxyzine, heparin, acenocumorol, warfarin, tadalafil, sildenafil.

I voluntarily agree to take the medication(s) listed above as prescribed by the psychiatric provider. I understand that I may choose to withdraw this permission in the future at my discretion. I have had an opportunity to ask any questions, and I am satisfied with the explanations. All the side-effects listed above have been explained to me, and I understand the risks and benefits of taking this medication.

_____ _____ _____ _____
Psychiatric Provider Signature Date Patient's Signature Date

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SERVICIOS DE SALUD MENTAL

FORMULARIO DE CONSENTIMIENTO PARA MEDICAMENTOS

Anti-Depresivos

Patient Name	*Patient Number*	*Booking Number*	*Date of Birth*	*Today's Date*

Yo
estoy de acuerdo con el tratamiento de los siguientes medicamentos en la dosis recomendada para mí por el especialista psiquiátrico.

( ) Trazodone ( ) Wellbutrin ( ) Antidepresivos tricíclicos (TCA)
( ) La mirtazapina ( ) ISRS ( ) IRSN (Effexor, Cymbalta, Pristiq)
( ) Otro

He sido informado de que los siguientes beneficios pueden ocurrir por tomar estos medicamentos:
La disminución de los síntomas de depresión (estado de ánimo deprimido, ansiedad, insomnia, exceso de sentimiento de culpa, bajo auto estima, falta de energía, agitación, falta de concentración), y / o síntomas de ansiedad.

He sido informado de que los posibles efectos secundarios por tomar estos medicamentos pueden ser:

( ) Todos los medicamentos siguientes:
priapismo (priapismo es una erección persistente y dolorosa (pene erecto) que dura más de 4 horas).Este es un efecto sexual secundario raro pero grave que si no se trata inmediatamente pueden conducir a la cicatrización y la disfunción eréctil permanente (pérdida de la función sexual).Alerte al personal médico inmediatamente si usted experimenta estos síntomas.
( ) Todos los medicamentos siguientes:
manía / hipomanía (exceso de energía), sedación, náuseas / vómitos, deterioro cognitivo y efectos motoros (pensamiento acelerado, fatiga), disfunción sexual (deseo sexual), ansiedad, síndrome de abstinencia, astenia (pérdida de energía) , aumento de ideas suicida

( ) Trazodone	mareos, náuseas, congestión nasal
( ) TCA	bocs seca, estreñimiento, visión borrosa, dificultad para orinar, defectos cardíaca, hipo / hipertensión (alta / baja presión arterial), aumento de peso, sudoración
( ) ISRS	náuseas, diarrea, dolores de cabeza, ansiedad, insomnia, fatiga, temblores, acatisia (inquietud)
( ) IRSN	náuseas, dolores de cabeza, sudoración, insomnio, hipertensión (no Cymbalta)
( ) Wellbutrin	dolores de cabeza, náuseas, ansiedad, insomnio, convulsiones
( ) Mirtazapina	boca seca, estreñimiento, sedación, neutropenia, aumento de peso
( ) _____	_____

El uso acompañante de otros medicamentos puede aumentar el riesgo de priapismo, incluyendo los antipsicóticos típicos, y la clozapina, risperidona, olanzapina, aripriprazole, quetiapina, terazosina, tamsulosina, alfuzosina, prazosina, hidralazina, buspirona, hidroxizina, la heparina, acenocumorol, warfarina, tadalafilo, sildenafilo .

Acepto voluntariamente tomar el/los medicamento(s) que figuran(n) en la forman prescrita por el especialista psiquiátrico.Yo entiendo que puedo optar por retirar este permiso en el futuro a mi discreción. He tenido la oportunidad de hacer preguntas, y estoy satisfecho con las explicaciones.Todos los efectos secundarios mencionados anteriormente se me han explicado y entiendo los riesgos y beneficios de tomar estos medicamentos.

_____ _____
Firma del Especialista Psiquiátrico Fecha Firma del Paciente Fecha

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Mental Health Services

Medication Consent Form

Anti-Eps

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

I,

agree to treatment with the following medications in the dosage recommended to me by the psychiatric provider:

( ) Cogentin
( ) Artane
( ) Benadryl
( ) _____

I have been made aware that the following are benefits that may occur through taking these medications:

decrease tremors, muscle stiffness, restlessness, involuntary movements, anxiety, and insomnia, increase sedation

I have been made aware that possible side effects of taking these medications may be:

( ) Cogentin:	dry mouth, blurry vision, constipation, confusion
( ) Artane:	dry mouth, blurry vision, constipation, confusion, nausea, nervousness
( ) Benadryl:	sedation, dry mouth, constipation, insomnia
( ) _____	_____

I voluntarily agree to take the medication(s) listed above as prescribed by the psychiatric provider. I understand that this permission may be revoked at my discretion. I have had an opportunity to ask any questions, and I am satisfied with the explanations.

_____ _____
Psychiatric Provider Signature Date

_____ _____
Patient's Signature Date

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SERVICIOS DE SALUD MENTAL

FOMULARIO DE CONSENTIMIENTO PARA MEDICAMENTOS

Anti-Sintomas Extrapiramidales

CCS CORRECT CARE SOLUTIONS

Patient Name	*Patient Number*	*Booking Number*	*Date of Birth*	*Today's Date*

Yo

estoy de acuerdo con el tratamiento de los siguientes medicamentos en la dosis recomendada para mí por el especialista psiquiátrico:

( ) Cogentin ( ) Artane ( ) Benadryl ( ) _____

He sido informado de que los siguientes beneficios se pudieran producir por tomar estos medicamentos:

disminuciónde temblores, rigidez muscular, agitación, movimientos involuntarios, ansiedad e insomnia, aumento de la sedación

He sido informado de que los posibles efectos secundarios de tomar estos medicamentos pueden ser:

( ) Cogentin: boca seca, visión borrosa, estreñimiento, confusión
( ) Artane: boca seca, visión borrosa, estreñimiento, confusión, náuseas, nerviosismo
( ) Benadryl: sedación, boca seca, estreñimiento, insomnio
( ) _____ _____

Acepto voluntariamente tomar el/los medicamento(s) que figura(n) en la forma prescrita por el especialista psiquiátrico.Entiendo que este permiso puede ser revocado a mi discreción. He tenido la oportunidad de hacer preguntas, y estoy satisfecho con las explicaciones.

_____ _____

Firma del Especialista Psiquiátrico Fecha Firma del Paciente Fecha

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Anti eps

Mental Health Services

Medication Consent Form

Anti-Psychotics

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

I,

agree to treatment with the following medications in the dosage recommended to me by the psychiatric provider:

( ) Haldol ( ) Prolixin ( ) Seroquel ( ) Zyprexa
( ) Navane ( ) Stelazine ( ) Risperdal ( ) Abilify
( ) Thorazine ( ) Geodon ( ) Clozaril ( ) Invega
( ) Other: _____

I have been made aware that the following are benefits that may occur through taking these medications:

decrease hallucinations, delusions, thought disorder, agitation

I have been made aware that possible side effects of taking these medications may be:

( ) All meds below: sedation, tardive dyskinesia, parkinsonism, impaired judgment / concentration / thinking / motor skills, elevated prolactin levels, disruption of temperature regulation, dysphagia (difficulty swallowing), weight gain, hypotension, dry mouth, blurry vision, urinary hesitancy, constipation, amenorrhea, asthenia, neuroleptic malignant syndrome, priapism (priapism is a persistent and painful erection (hard penis) that lasts more than 4 hours). This is a rare but serious sexual side effect that if not treated immediately can lead to scarring and permanent erectile dysfunction (loss of sexual function). Alert medical staff immediately if you experience these symptoms.

( ) Haldol ( ) Navane ( ) Thorazine ( ) Prolixin ( ) Stelazine ( ) Other: _____

( ) All meds below: priapism (priapism is a persistent and painful erection (hard penis) that lasts more than 4 hours). This is a rare but serious sexual side effect that if not treated immediately can lead to scarring and permanent erectile dysfunction (loss of sexual function). Alert medical staff immediately if you experience these symptoms.

( )Clozaril ( ) Risperdal ( ) Zyprexa ( ) Abilify ( ) Seroquel ( ) Other: _____

( ) All atypicals below: When given to elderly patients with dementia related psychosis there is an increased risk of sudden death. The cause of death has been either cardiovascular (e.g. stroke, TIA, heart failure, sudden death) or infections.

( ) Geodon QT prolongation, rash, hypertension, vomiting, agitation, confusion, hyperglycemia, diabetes,

( )Seroquel dizziness, hypothyroidism (decreased thyroid activity), elevated cholesterol, cataracts, hyperglycemia, diabetes

( ) Risperdal tachycardia, arthralgia (joint pain), rhinitis, infection, nervousness, hyperglycemia, diabetes, hyperprolactinemia (with lactation)

( ) Clozaril agranulocytosis (condition involving white blood cells), excess salivation, seizures, tachycardia, leucopenia, hyperglycemia, diabetes

( ) Zyprexa headache, sedation, insomnia, agitation, nervousness, hostility, dizziness, weight gain, hyperglycemia, diabetes

( ) Abilify sinusitis, depression, tachycardia, anemia, anxiety, insomnia, constipation

( ) Invega rhinitis, extrapyramidal symptoms, hyperglycemia, hyperprolactinemia (with lactation)

( ) _____

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Patient Name	Inmate Number	Booking Number	Date of Birth	Today's Date

Concurrent use of other medications may increase the risk of priapism, including typical antipsychotics, all classes of antidepressants, terazosin, tamsulosin, alfuzosin, prazosin, hydralazine, buspirone, hydroxyzine, heparin, acenocumorol, warfarin, tadalafil, sildenafil.

I voluntarily agree to take the medication(s) listed above as prescribed by the psychiatric provider. I understand that I may choose to withdraw this permission in the future at my discretion. I have had an opportunity to ask any questions, and I am satisfied with the explanations. All the side effects listed above have been explained to me, and I understand the risks and benefits of taking this medication.

Psychiatric Provider Signature _____ Date _____

Patient's Signature _____ Date _____

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SERVICIOS DE SALUD MENTAL

FORMULARIO DE COMSENTIMIENTO PARA MEDICAMENTOS

Anti-psicóticos

CCS CORRECT CARE SOLUTIONS

Patient Name	*Patient Number*	*Booking Number*	*Date of Birth*	*Today's Date*

Yo
estoy de acuerdo con el tratamiento de los siguientes medicamentos en la dosis recomendada para mí por el especialista psiquiátrica:

( ) Haldol
( ) Navane
( ) Thorazine
( ) Otro: _____
( ) Prolixin
( ) Stelazine
( ) Geodon
( ) Seroquel
( ) Risperdal
( ) Clozaril
( ) Zyprexa
( ) Abilify
( ) Invega

He sido informado de que los siguientes beneficios se pudieran producir por tomar estos medicamentos:

disminución de alucinaciones, delirios, trastornos del pensamiento, agitación

He sido informado de que los posibles efectos secundarios de tomar estos medicamentos pueden ser:

( ) Todos los medicamentos siguientes:

sedación, discinesia tardía, parkinsonismo, falta de juicio / concentración / pensamiento / capacidad motora, niveles elevados de prolactina, interrupción de la regulación de la temperatura, disfagia (dificultad para tragar), aumento de peso, hipotensión, sequedad de boca, visión borrosa, ganas de orinar, estreñimiento, amenorrea, astenia, síndrome neuroléptico maligno, priapismo (priapismo es una erección persistente y dolorosa (pene erecto) que dura más de 4 horas).Este es un efecto sexual secundario raro pero grave que si no se trata inmediatamente puede conducir a la cicatrización y la disfunción eréctil permanente (pérdida de la función sexual). Alerte al personal médico inmediatamente si usted experimenta estos síntomas.

( ) Haldol ( ) Navane ( ) Thorazine ( ) Prolixin ( ) Stelazine ( ) Otro: _____

( ) Todos los medicamentos siguientes:

priapismo (priapismo es una erección persistente y dolorosa (pene erecto) que dura más de 4 horas).Este es un efecto sexual secundario raro pero grave que si no se trata inmediatamente puede llevar a cicatrices y una disfunción eréctil permanente (pérdida de la función sexual). Alertar al personal médico inmediatamente si usted experimenta estos síntomas.

( ) Clozaril ( ) Risperdal ( ) Zyprexa ( ) Abilify ( ) Seroquel ( ) Otro: _____

( ) Todos los antipsicóticos atípicos a continuación:

Cuando se administra a pacientes ancianos con demencia relacionada con psicosis hay un mayor riesgo de muerte súbita. La causa de la muerte ha sido de naturaleza cardiovascular (por ejemplo ictus, ataque isquémico transitorio, insuficiencia cardiaca, muerte súbita) o infecciones.

( ) Geodon prolongación del intervalo QT, erupción cutánea, hipertensión, vómitos, agitación, confusión, hiperglucemia, diabetes

( ) Seroquel hipotiroidismo (disminución de la actividad tiroidea), colesterol elevado, cataratas, hiperglucemia, la diabetes

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SERVICIOS DE SALUD MENTAL

FORMULARIO DE COMSENTIMIENTO PARA MEDICAMENTOS

Anti-psicóticos

CCS CORRECT CARE SOLUTIONS

Patient Name	Patient Number	Booking Number	Date of Birth	Today's Date

( ) Risperdal taquicardia, artralgia (dolor articular), rinitis, infecciones, nerviosismo, hiperglucemia, diabetes, hiperprolactinemia (con la lactancia)

( ) Clozaril agranulocitosis (condición que involucra las células blancas de la sangre), salivación excesiva, convulsiones, taquicardia, leucopenia, hiperglucemia, diabetes

( ) Zyprexa dolor de cabeza, sedación, insomnio, agitación, nerviosismo, hostilidad, mareos, aumento de peso, hiperglucemia, la diabetes

( ) Abilify sinusitis, depresión, taquicardia, anemia, ansiedad, insomnia, estreñimiento

( ) Invega rinitis, síntomas extrapiramidales, la hiperglucemia, la hiperprolactinemia (con la lactancia)

( ) _____

El uso acompañante de otros medicamentos puede aumentar el riesgo de priapismo, incluyendo los antipsicóticos típicos, todas las clases de antidepresivos, terazosina, tamsulosina, alfuzosina, prazosina, hidralazina, buspirona, hidroxizina, heparina, acenocumorol, warfarina, tadalafilo, sildenafilo.

Acepto voluntariamente tomar el/los medicamento(s) que figura(n) en la forma prescrita por el proveedor psiquiátrico.Yo entiendo que puedo optar por retirar este permiso en el futuro a mi discreción.He tenido la oportunidad de hacer preguntas, y estoy satisfecho con las explicaciones.Todos los efectos secundarios mencionados anteriormente se me han explicado, y entiendo los riesgos y beneficios de tomar este medicamento

_____ _____

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Mental Health Services

Medication Consent Form

Colace

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

I,

agree to treatment with the following medications in the dosage recommended to me by the psychiatric provider:

( ) Colace
( ) _____

I have been made aware that the following are benefits that may occur through taking these medications:

decrease constipation

I have been made aware that possible side effects of taking these medications may be:

( ) Colace: nausea
( ) _____

I voluntarily agree to take the medication(s) listed above as prescribed by the psychiatric provider. I understand that this permission may be revoked at my discretion. I have had an opportunity to ask any questions, and I am satisfied with the explanations.

_____ _____ _____ _____
Psychiatric Provider Signature Date Patient's Signature Date

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SERVICIOS DE SALUD MENTAL

FORMULARIO DE CONSENTIMIENTO PARA MEDICAMENTOS
Colace (laxante)

CCS CORRECT CARE SOLUTIONS

Patient Name	*Patient Number*	*Booking Number*	*Date of Birth*	*Today's Date*

Yo

estoy de acuerdo con el tratamiento de los siguientes medicamentos con la dosis recomendada para mí por el especialista psiquiátrico:

( ) Colace ( ) _____

He sido informado de que los siguientes beneficios se pudieran producir por tomar estos medicamentos:

reducir el estreñimiento

He sido informado de que los posibles efectos secundarios de tomar estos medicamentos pueden ser:

( ) Colace: náuseas
( ) _____

Acepto voluntariamente tomar el/los medicamento(s) que figuran en la forma prescrita por el proveedor psiquiátrico. Entiendo que este permiso puede ser revocado a mi discreción. He tenido la oportunidad de hacer preguntas, y estoy satisfecho con las explicaciones.

_____ _____

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Mental Health Services

Medication Consent Form

Mood Stabilizers

Patient Name	*Patient Number*	*Booking Number*	*Date of Birth*	*Today's Date*

I,

agree to treatment with the following medications in the dosage recommended to me by the psychiatric provider:

( ) Lithium
( ) Carbamazepine
( ) Valproic Acid
( ) Lamotrigine
( ) Oxcarpazepine

I have been made aware that the following are benefits that may occur through taking these medications:

Decreased episodes of mania and/or depression, and decreased aggressive behavior.

I have been made aware that possible side effects of taking these medications may be:

( ) Lithium	hypothyroidism (decreased thyroid activity), decreased kidney concentrating ability, tremor, nausea vomiting, diarrhea, ataxia
( ) Carbamazepine	aplastic anemia, agranulocytosis, photosensitivity (sensitivity to sunlight), nausea, water retention, serious rash
( ) Valproic Acid	liver toxicity, pancreatitis, decreased platelets, headache, nausea, diarrhea, sedation, serious rash
( ) Lamotrigine	serious rash, headache, nausea, insomnia
( ) Oxcarpazapine	headache, serious rash, hyponatremia (decreased sodium) and agranulocytosis (rare)
( ) All above meds:	sedation, fatigue, poor concentration, psychomotor slowing, confusion, ataxia (difficulty coordinating movement), memory impairment, dizziness, tremor

I voluntarily agree to take the medication(s) listed above as prescribed by the psychiatric provider. I understand that I may choose to withdraw this permission in the future at my discretion. I have had an opportunity to ask any questions, and I am satisfied with the explanations.

Psychiatric Provider Signature Date

Patient's Signature Date

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Mental Health
SFI Progress Note

Patient Name	Inmate Number	Booking Number	Date of Birth	Today's Date

Current Status and Progress Since Last Appointment: _____

_____

_____

_____

_____

_____

_____

Describe Interventions Utilized/Skills Taught During Session: _____

_____

_____

Medication Compliant? ❑ N/A ❑ Yes ❑ No

Suicidal Ideations noted? ❑ N/A ❑ Yes ❑ No

Homicidal Ideations noted? ❑ N/A ❑ Yes ❑ No

Mental Status Exam:

Appearance:	Speech:	Mood:	Affect:	Thought Form:	Thought Content:
❑ Appropriate	❑ Appropriate	❑ Appropriate	❑ Appropriate	❑ Coherent	❑ Appropriate
❑ Meticulous	❑ Expressive	❑ Depressed	❑ Tearful	❑ Circumstantial	❑ Comp/obsess.
❑ Unclean	❑ Loud	❑ Euphoric	❑ Blunted	❑ Tangential	❑ Thought insertion
❑ Disheveled	❑ Slowed	❑ Anxious	❑ Flat	❑ Loose Assoc.	❑ Broadcasting
❑ Bizarre	❑ Pressured	❑ Angry	❑ Labile	❑ Poverty of Thought	❑ Delusional
❑ Other _____	❑ Slurred	❑ Irritable	❑ Hostile	❑ Flight of Ideas	❑ Other_____
	❑ Other _____	❑ Other _____	❑ Other _____	❑ Other_____	
Orientation:	**Intelligence:**	**Memory:**	**Insight:**	**Judgment:**	**Behavior:**
❑ Person	❑ Above Average	❑ Intact	❑ Intact	❑ Intact	❑ Appropriate
❑ Place	❑ Average	❑ Immediate Impaired	❑ Good	❑ Good	❑ Belligerent
❑ Purpose	❑ Below Average	❑ Recent Impaired	❑ Fair	❑ Fair	❑ Agitated
❑ Time	❑ Developmentally Disabled	❑ Remote Impaired	❑ Poor	❑ Poor	❑ Withdrawn

Does treatment plan require revision based on current status? ❑ Yes ❑ No Note changes: _____

_____

Mental Health Diagnoses:

Axis I: _____

_____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

Plan:

(Please check all that apply)

❑ Continue Special Needs Visits. Follow up in _____days.

❑ Start Suicide Precautions: _____

❑ Refer to Psychiatry: _____

❑ Refer to Medical: _____

❑ D/C from SFI program - MH to f/u in 1 month to assess adjustment. (List reason for d/c) : _____

❑ Other: _____

_____ Signature

_____ Date/Time

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SERVICIOS DE SALUD MENTAL

FORMULARIO DE COMSENTIMIENTO PARA MEDICAMENTOS

Estabilizadores del Estado de Animo

CCS CORRECT CARE SOLUTIONS

Patient Name	*Patient Number*	*Booking Number*	*Date of Birth*	*Today's Date*

Yo
estoy de acuerdo con el tratamiento de los siguientes medicamentos en la dosis recomendada para mí por el especialista psiquiátrico.

( ) Lithium
( ) Carbamazepina:
( ) ácido valproico
( ) La lamotrigina
( ) Oxcarpazepine
( ) _____

He sido informado de que los siguientes beneficios se pudieran producir por tomar estos medicamentos:

Disminución de los episodios de manía y / o depresión, y disminución de la conducta agresiva.

He sido informado de que los posibles efectos secundarios de tomar estos medicamentos pueden ser:

( ) Lithium	Hipotiroidismo (disminución de la actividad de la tiroides), disminución de la capacidad del riñón, temblor, náuseas, vómitos, diarrea, ataxia
( ) Carbamazepina	anemia aplásica, agranulocitosis, fotosensibilidad (sensibilidad a la luz del sol), náuseas, retención de agua
( ) Acido Valproico	toxicidad hepática, pancreatitis, disminución de las plaquetas, dolor de cabeza, náuseas, diarrea, sedación
( ) La lamotrigina	erupción cutánea grave, dolor de cabeza, náuseas, insomnio
( ) Oxcarpazepine	dolor de cabeza, erupción cutánea grave, hiponatremia (disminución de sodio) y agranulocitosis (poco frecuente)

( ) Todos los medicamentos anteriores:

sedación, fatiga, mala concentración, el enlentecimiento psicomotor, confusión, ataxia (dificultad en el movimiento de coordinación), pérdida de memoria, mareos, temblor

( ) _____

Acepto voluntariamente tomar el/los medicamento(s) que figura(n) en la forma prescrita por el proveedor psiquiátrico.Yo entiendo que puedo optar por retirar este permiso en el futuro a mi discreción. He tenido la oportunidad de hacer preguntas, y estoy satisfecho con las explicaciones.

_____ _____

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MENTAL HEALTH SERVICES AIMS

Patient Name	*Number*	*Booking Number*	*Date of Birth*	*Today's Date*

		None	Minimal	Mild	Moderate	Severe
FACIAL AND ORAL MOVEMENTS	**1. Muscles of Facial Expression** (e.g., movements of forehead, eyebrows, periorbital area, cheeks, include frowning, blinking, smiling, grimacing).	0	1	2	3	4
	2. Lips and Perioral Area (e.g., puckering, pouting, smacking).	0	1	2	3	4
	3. Jaw (e.g., biting, clenching, chewing, mouth opening lateral movement).	0	1	2	3	4
	4. Tongue (rate only increase in movement both in and out of mouth, NOT inability to sustain movement).	0	1	2	3	4
EXTREMITY MOVEMENTS	**5. Upper (arms, wrists, hands, fingers)** (include choreic movements [i.e., rapid, objectively purposeless, irregular, spontaneous], athetoid movements [i.e., slow, irregular, complex, serpentine]. Do NOT include tremor [i.e., repetitive, regular, rhythmic]).	0	1	2	3	4
	6. Lower (legs, knees, ankles, toes) (e.g., lateral knee movement, foot tapping, heel dropping, foot squirming, inversion and eversion of foot).	0	1	2	3	4
TRUNK MOVEMENTS	**7. Neck, Shoulders, Hips** (e.g., rocking, twisting, squirming, pelvic gyration).	0	1	2	3	4
GLOBAL JUDGMENT	**8. Severity of Abnormal Movements**	0	1	2	3	4
	9. Incapacitation Due to Abnormal Movements	0	1	2	3	4
	10. Patient's Awareness of Abnormal Movement (rate only patient's report)	No awareness Aware, no distress Aware, mild distress Aware, moderate distress Aware, severe distress			0 1 2 3 4	
	11. Current problems with teeth and/or dentures	No Yes			0 1	
	12. Does patient usually wear dentures?	No Yes			0 1	

(A positive AIMS examination is a score of 2 in two or more movements or a score of 3 or 4 in a single movement.)

Comments

_____

_____

_____

_____

AIMS Assessed by: _____ Date: _____

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Mental Health Activity Therapy Note

Patient Name	Inmate Number	Booking Number	Date of Birth	Today's Date

Group Topic: _____

Describe Group Activity: _____

_____

Client Response to Topic: _____

_____

_____

Communication:	Behavior:	Hygiene:
❑ Initiated conversation ❑ Stated thoughts/feelings clearly ❑ Made supportive comments to others ❑ Quiet but responded to others ❑ Made negative self-directed comments ❑ Statements not reality oriented ❑ Speech pressured ❑ Willing to listen to others ❑ Accepted positive feedback ❑ Interrupts	❑ Made independent decisions ❑ Required prompting from staff ❑ Refused to participate ❑ Had good eye contact ❑ Avoided eye contact ❑ Able to stay on task ❑ Not able to stay on task ❑ Demanding of others ❑ Argumentative ❑ Influenced by others ❑ Quiet and withdrawn ❑ Threatening/Dominating ❑ Easily frustrated	❑ Hygiene Appropriate ❑ Hygiene Poor **Other Comments:**

Plan:
(Please check all that apply)

❑ Continue Activity Therapy. Next session _____

❑ Refer to Mental Health for Routine Follow-up. Reason: _____

❑ Refer to Mental Health for Urgent Follow-Up. Reason: _____

❑ Refer to Medical. Reason: _____

❑ Homework assigned (specify) _____

❑ Discontinue from Activity Therapy. Reason: _____

❑ *Other:* _____

_____ _____
Signature Date/Time

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Mental Health Group Note

Patient Name	Inmate Number	Booking Number	Date of Birth	Today's Date

Type of Group: _____

Topic of Session: _____

_____

_____

_____

Client Response to Topic: _____

_____

_____

_____

Client Hygiene: _____

Communication/Social Behavior: (please check all that apply)

- ❑ Stated thoughts/feelings clearly
- ❑ Made negative self-directed comments
- ❑ Made independent decisions
- ❑ Demanding of others
- ❑ Willing to listen to others
- ❑ Argumentative
- ❑ Interrupts
- ❑ Able to stay on task
- ❑ Made supportive comments to others
- ❑ Statements not reality oriented
- ❑ Refused to participate
- ❑ Not able to stay on task
- ❑ Influenced by others
- ❑ Accepted positive feedback
- ❑ Had good eye contact
- ❑ Threatening/Dominating
- ❑ Quiet but responded to others
- ❑ Initiated conversation
- ❑ Avoided eye contact
- ❑ Speech pressured
- ❑ Quiet and withdrawn
- ❑ Required prompting from staff
- ❑ Easily frustrated
- ❑ Other: _____

Note treatment plan goals targeted by this group: _____

_____

_____

Treatment Plan Reviewed? ❑ Yes ❑ No

Changes Required? ❑ Yes ❑ No

Plan:

(Please check all that apply)

- ❑ Continue MH Group. Next session _____
- ❑ Refer to Mental Health for individual follow-up
- ❑ Refer to Psychiatry: _____
- ❑ Start Suicide Precautions: _____
- ❑ Homework assigned (specify) _____
- ❑ Refer to Medical: _____
- ❑ Refer to Activity Therapy: _____
- ❑ Other: _____
- ❑ Discontinue from Mental Health Group. MH to follow-up in 1 week to assess adjustment. (note reason for discontinuation)

_____

_____

_____ Signature

_____ Date/Time

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Mental Health Progress Notes

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

Date/Time	ALLERGIES _____

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CCS-MH01

Segregation Review - 30/60/90 Day Evaluation

Patient Name	*Patient Number*	*Booking Number*	*Date of Birth*	*Today's Date*

Date Entered Segregation: _____ ☐30 Day Review ☐60 Day Review ☐90 Day Review

This evaluation is a review of this patient's placement on segregation status. The information contained in this evaluation was obtained from contact with the patient during weekly segregation rounds, segregation review, clinical interviews, and behavioral observations during this patient's placement in segregation.

Please check (☑), as appropriate.

- ☐ No psychotic symptoms, suicidal ideation or mental deterioration noted during interview
- ☐ Anxiety, worry or tension apparent during interview
- ☐ Significant depression noted during interview
- ☐ Delusional thinking apparent during interview
- ☐ Time orientation and/or memory problems apparent during interview
- ☐ Suicidal ideation reported
- ☐ Homicidal ideation reported
- ☐ Hallucination reported (auditory, visual, olfactory)
- ☐ Patient denied psychotic symptoms
- ☐ This patient receives psychotropic medication
  - ☐ Compliant ☐ Non-compliant (see comments below)

RECOMMENDATIONS

- ☐ Continued segregation placement with no mental health restrictions
- ☐ Symptoms of psychosis, suicidal ideation or mental deterioration noted during interview. Patient referred to psychiatrist for further evaluation.
- ☐ This patient can continue segregation placement only with the following mental health recommendations listed below
- ☐ This patient requires immediate removal from segregation due to mental health reasons

COMMENTS

_____

_____

_____

_____

_____

Next Review Due: _____

Signature: _____ Date: _____

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SELF HARM WATCH/MH
OBSERVATION FOLLOW-UP NOTE

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

Status: ❑Self-Harm Watch ❑MH Obs ***Reason for Visit*** ❑ Daily ❑ S/P SW 24 hrs ❑ S/P SW D7 ❑ S/P SW D14
Frequency: ❑Close Obs ❑15/min ❑30/min
Mental Status:

Sensorium:	Behavior:	Mood:	Thought Process:	Thought Content:
❑ Alert ❑ Oriented x 3 ❑ Distractible ❑ Poor concentration ❑ Other _____	❑ Calm ❑ Agitated ❑ Slowed ❑ Other_____	❑ Euthymic ❑ Depressed ❑ Anxious ❑ Elevated ❑ Irritable ❑ Other_____	❑ Goal-Directed ❑ Disorganized ❑ Loose Associations ❑ Tangential ❑ Other_____	❑ Homicidal ❑ Suicidal ❑ Paranoid ❑ Hallucinations ❑ Delusions ❑ Other_____
Appearance:	**Speech:**	**Affect:**	**Memory:**	**Cognitive Estimate:**
❑ Well kept ❑ Self-neglect ❑ Other_____	❑ Clear/Coherent ❑ Spontaneous ❑ Pressured ❑ Poverty ❑ Other_____	❑ Appropriate ❑ Inappropriate ❑ Constricted ❑ Blunted ❑ Other_____	❑ Recent Intact ❑ Remote Intact ❑ Impaired ❑ Other_____	❑ High ❑ Average ❑ Low

Risk Assessment: Current Ideation: ❑ Yes ❑ No ❑ Refuses to answer **Current Plan:** ❑ Yes ❑ No ❑ Refuses to answer
Any self harm since last MHP visit? ❑ Yes ❑ No If Yes, describe: _____

Review status of factors that lead to placement on watch/observation: _____

_____

_____

Medication: ❑ Yes ❑ No **Compliant:** ❑ Yes ❑ No ❑ N/A

Client's subjective report: _____

_____

Interventions utilized during meeting: _____

_____

_____

Plan – Complete this Section for Visits Completed While Client on Watch or Observation Status:

- ❑ Continue watch – daily follow-up
- ❑ Discontinue watch – (complete discharge form)
- ❑ Refer to Psychiatry
- ❑ Consult with MH Supervisor
- ❑ Refer for SFI status
- ❑ Change property/clothing: _____
- ❑ Change meals: _____
- ❑ Changes to recreation status: _____
- ❑ Changes in Sharps restrictions: _____
- ❑Case worker informed of recommended changes to watch conditions
- ❑Other: _____

Plan – Complete this Section for Post Release Visits

- ❑ Initiate Suicide Watch (why)_____
- ❑ Initiate MH Obs (why) _____
- ❑ MH F/U Date: _____
- ❑ Refer to SFI Program
- ❑ Refer to MH Group
- ❑ Other _____
- ❑ *Plan for MH F/U after S/P D14 visit:* _____

_____ _____
Signature **Date & Time**

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Self Harming and SFI
Daily Segregation Assessment Form

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

Date Assigned: _____ **Date Released:** _____

Assigned by: ____**Correctional Personnel** _____**Health Personnel**

_____ SFI ____SelfHarming ____Refer to MH

Note: Health staff will initiate observation rounds on the day the inmate is placed in segregation. Inmates placed in segregation will have their vital signs checked weekly.

If any box with a "*" is checked off, mental health is to be notified immediately.

Date: _____ **Time:** _____ **Location:** _____

Person performing Observation:_____

Assessment/Notes	**Yes**	**No**
Is the inmate alert and oriented		*
Are there any signs of increased depression	*	
Has the inmate exhibited any signs of suicidal ideation	*	
Has the inmate exhibited any symptoms of psychosis	*	
Is the inmate making progress in transferring out of segregation status	*	
Health Complaints/Notes:		

Date: _____ **Time:** _____ **Location:** _____

Person performing Observation:_____

Assessment/Notes	**Yes**	**No**
Is the inmate alert and oriented		*
Are there any signs of increased depression	*	
Has the inmate exhibited any signs of suicidal ideation	*	
Has the inmate exhibited any symptoms of psychosis	*	
Is the inmate making progress in transferring out of segregation status	*	
Health Complaints/Notes:		

Date: _____ **Time:** _____ **Location:** _____

Person performing Observation:_____

Assessment/Notes	**Yes**	**No**
Is the inmate alert and oriented		*
Are there any signs of increased depression	*	
Has the inmate exhibited any signs of suicidal ideation	*	
Has the inmate exhibited any symptoms of psychosis	*	
Is the inmate making progress in transferring out of segregation status	*	
Health Complaints/Notes:		

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Suicide Potential Screening Form

Patient Name	*Patient Number*	*Booking Number*	*Date of Birth*	*Today's Date*

This form is to be completed at the second CIWA/COWS assessment. See bottom of chart for interpretation instructions and please note that these instructions are different from those found on the same screen used during the intake process.

	SUICIDE POTENTIAL SCREENING	CIRCLE	
1	Has had negative/distressing telephone or personal contact with family/friend since intake to facility.	YES	NO
2	Lacks close family/friends in community.	YES	NO
3	Worried about major problems other than legal situation (terminal illness).	YES	NO
4	Family member or significant other has attempted or committed suicide (spouse/parent/sibling/close friend/lover).	YES	NO
5	Has psychiatric history (psychotropic medication or treatment).	YES	NO
6	Holds position of respect in community (professional/public official) and/or alleged crime is shocking in nature. Expresses feelings of embarrassment/shame.	YES	NO
7	Expresses thoughts about killing self.	YES	NO
8	Has a suicide plan and/or suicide instrument in possession.	YES	NO
9	Has previous suicide attempt.	YES	NO
10	Expresses feelings there is nothing to look forward to in the future (feelings of helplessness and hopelessness).	YES	NO
11	Shows signs of depression (crying or emotional flatness).	YES	NO
12	Appears overly anxious, afraid or angry.	YES	NO
13	Appears to feel unusually embarrassed or ashamed.	YES	NO
14	Is acting and/or talking in a strange manner. (cannot focus attention/hearing or seeing things not there?	YES	NO
15	Is this individual's first arrest?	YES	NO

Immediate Action: A "YES" from shaded area, or a total of **4** or more "YES" responses, shall result in notification of custody as appropriate, and an immediate call to Mental Health. At no time should the patient be left alone.

_____ Mental Health contacted and orders received.

_____ No referral to Mental Health indicated based on results of Suicide Potential Screen

Nurse signature: _____

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Mental Health Treatment Plan

Patient Name	Inmate Number	Date of Birth	Today's Date

TREATMENT MODALITY: ☐ **SFI** ☐ **Group Therapy** ☐ **Individual Therapy**

DIAGNOSES*: Axis I:_____ Axis IV:_____

Axis II:_____ Axis V:_____

Axis III:_____

*If currently under psychiatric treatment, utilize diagnoses determined by psychiatric provider

Treatment Plan Development Date: _____

Focus of Treatment	Goal	Interventions	Progress Measurement Indicators	Dates
				Treatment Start Date: _____ Anticipated Completion Date: _____
				Treatment Start Date: _____ Anticipated Completion Date: _____
				Treatment Start Date: _____ Anticipated Completion Date: _____

Note: For clients' prescribed psychotropic medication – Psychiatric Provider shall review plan._____(initials)

_____ _____

Staff Signature Date Inmate Signature* Date

*I agree to participate in this treatment plan.

For clients' identified as SFI – Review Treatment Plan every three (3) months and sign below if no update is needed. All other treatment plans shall be updated at least every six (6) months.

Reviewing Staff Signature:_____ Review Date:_____

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