ADMINISTRATIVE POLICIES AND PROCEDURES State of Tennessee Department of Correction	Index #: 113.84	Page 1 of 10
	Effective Date: January 15, 2021	
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Approved by: Tony Parker		
Subject: CLINICAL ASSESSMENTS, MENTAL HEALTH APPRAISALS, AND PSYCHOLOGICAL TESTING		

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

II. PURPOSE: To ensure that psychological evaluations and clinical assessments are available at each institution to assist institutional staff in better determining an inmate's mental health needs.

III. APPLICATION: To Wardens, Superintendents of transition centers, mental health and physical health care providers, security staff, and personnel at privately managed institutions.

IV. DEFINITIONS:

A. Clinical Assessment: A direct assessment of an individual's mental health status, without the use of standardized psychological test(s), to determine and/or recommend the need for mental health treatment.

B. 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 a licensed professional counselor with health service provider designation. These individuals shall meet all educational competency and licensure/certification criteria mandated by their regulatory boards.

C. Mental Health Appraisal: A screening assessment to determine need for a mental health evaluation.

D. Psychological Testing: A direct administration of a single or battery of standardized psychological instrument(s) to an individual with the intent of establishing a clinical profile to aid in the diagnostic process and clinical disposition.

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

F. Segregation: The restrictive confinement of an inmate to an individual cell that is separate from the general population.

G. Test of Adult Basic Education (TABE): An examination used to place students in education and track their performance.

V. POLICY: As part of its mental health service delivery, each institution shall provide the resources necessary to perform clinical assessments/mental health appraisals and/or psychological testing through the appropriate mental health professional, acting within the scope of practice for such person's license or certification (with appropriate clinical supervision).

VI. PROCEDURES:

A. Clinical assessments, mental health appraisals and/or psychological testing pursuant to this policy will vary depending upon the needs of the inmate.

B. Inmates placed on mental health seclusion, suicide monitoring, or placed in therapeutic restraint shall receive the distinct assessments prescribed by Policies #506.07 and #113.88.

C. The management, documentation, and accessibility of all clinical assessments, mental health appraisals and psychological testing shall be governed by Policies #512.01, #113.52, #113.50, and #113.81.

D. The Tennessee Department of Correction (TDOC) shall adhere to the Federal Health and Human Services Alcohol and Drug Abuse Confidentiality regulations. (See Policy #113.52) Disclosure of any information about an inmate's treatment for substance abuse requires written consent from the inmate on Authorization for Release of Health Services Information, CR-1885.

E. When a mental health level of care/classification is assigned based on a clinical assessment or psychological testing outcome, the behavioral health administrator or designee shall ensure that mental health level of care is entered into LHSM in the offender management system (OMS).

F. If an inmate lacks the capacity to participate in the clinical assessment, mental health appraisal and/or psychological testing, process, the LIMHP shall use Problem Oriented Progress Record, CR-1884, to document any clinical symptoms. The mental health staff shall meet prior to expiration of the allocated timeframe for the evaluation to discuss placement and treatment options for the inmate. This may include transfer to a facility with a Supportive Living Unit and requires approval of placement by the Warden via electronic mail. The follow-up clinical assessment, mental health appraisal and/or psychological testing shall be conducted within 14 days of the inmate's return to stability.

G. Clinical Assessments in Segregation

1. Any inmate, outside of those receiving mental health services, who has been placed in disciplinary segregation or administrative segregation, protective custody, pending investigation, or safekeeper status must receive a clinical assessment within seven working days of placement, in order to assess for contraindications to segregation status. Inmates receiving mental health services shall receive a clinical assessment within 72 hours. The clinical assessment shall be conducted by a LIMHP, or a QMHP, under the supervision of a LIMHP.

2. An inmate confined to a segregation cell or locked down in any area of the institution for 22 hours each day for more than 30 consecutive days will be afforded an initial 30-day clinical assessment. Thereafter, the inmate will be assessed at 30-day intervals as long as the 22-hour per day confinement continues. Allowing an inmate additional brief time out of cell (e.g., two hours) while on segregation status does not eliminate the requirement for 72 hours, seven, and 30-day clinical assessments. Clinical assessments may be provided more frequently if determined necessary by the LIMHP or by a

QMHP, under the supervision of a LIMHP. A clinical assessment may also be requested by a mental health treatment team, Warden or designee for inmates placed in any segregation status for less than 30 days if the inmate's mental and/or emotional stability is in question.

3. The 72 hours, seven, and 30-day clinical assessments shall be provided by the LIMHP or by a QMHP, under the supervision of a LIMHP, by means of direct contact with the inmate.

4. Due to the specialized treatment mission of the Level 3 and Level 4 units 30-day assessments shall not be required on these units.

5. Mental Health Screening Report, CR-2629, shall be exclusively utilized as a screening mechanism to document the required 72 hours, seven, and 30-day segregation clinical assessments. In no event shall CR-2629 be utilized to document a routine mental health contact.

H. Psychological Evaluations, Clinical Assessments and Mental Health Appraisals

1. Inmates who have a history of a diagnosed mental illness, particularly those who have demonstrated violent behavior, shall receive a clinical assessment by a LIMHP within 90 days prior to reclassification to minimum direct custody or trusty status. For placement in minimum custody to occur, the clinical assessment should indicate that the inmate is mentally and behaviorally stable, devoid of any gross indicators of acute psychosis, and would not be dangerous to self or others. The LIMHP conducting the assessment should also address the following questions in the report:

   a. Does significant mental illness exist which would pose a likelihood of serious harm to the inmate or to others?

   b. Does the inmate have symptoms of mental illness which would support referral for mental health treatment?

   c. Is there a likelihood of substantial mental deterioration if the inmate is placed in a less restrictive environment?

   d. If the inmate is receiving psychopharmacological intervention, has the inmate demonstrated a compliant pattern of treatment?

2. Inmates with a mental health Level of Care 3 or above who qualify for minimum secure housing, transition and/or transfer to a release center which takes place outside a secure facility shall be provided a clinical assessment by a LIMHP. (See Policy #404.07) Inmates with a mental health Level of Care 2 shall be reviewed and approved by the treatment team. Treatment team review and recommendation shall be documented on Problem Oriented Progress Record, CR-1884.

3. The most current version of the TABE shall be utilized during initial classification. Education staff shall have primary responsibility for TABE testing, including test administration, scoring, interpretation, and data entry. Upon arrival at a diagnostic center, an initial mental health appraisal shall be provided to each new inmate within

14 days of arrival by a LIMHP or QMHP. At the discretion of the LIMHP, it will be acceptable to utilize alternative psychological instruments for individuals identified as having special needs or when an inmate presents with new or novel symptoms of mental illness. The psychiatrist or APN, at their discretion, may also utilize additional diagnostic instruments to ascertain the clinical needs of an inmate. This may include, but not be limited to, the Abnormal Involuntary Movement Scale (AIMS), CR-3789. The CR-3789, along with other psychiatric diagnostic findings, shall be filed in Section 10 of the health record.

4. If a parole or probation violator/escapee has been out of the physical custody of TDOC, the returning inmate shall receive an initial mental health appraisal. Additional psychological/psychiatric intervention shall be prompted only based upon the clinical judgment of the interviewing clinician. If a parole/probation violator/escapee has been out of the physical custody of the TDOC for more than five years, the initial appraisal shall also recommend whether previous intellectual and achievement test results should be relied upon, or if re-testing in these areas is appropriate.

5. Each mental health appraisal conducted as part of the initial classification or reclassification process shall be documented on the Mental Health Intake Appraisal and Evaluation, CR-4180, which addresses/explores the following subjects/domains:

    a. Assessment of current mental status and condition

    b. Assessment of current suicide potential and person-specific circumstances that increase suicide potential

    c. Assessment of violence potential and person-specific circumstances that increase violence potential

    d. Request and review of any available historical records of inpatient and outpatient mental health treatment

    e. Request and review of history of treatment with psychotropic medication

    f. Review of history of psychotherapy, psycho-educational groups and classes or support groups

    g. Review of history of drug and alcohol treatment

    h. Review of educational history

    i. Review of history of sexual abuse/victimization and predatory behavior

    j Assessment of drug and alcohol abuse and/or addiction

6. If an inmate has previously expired TDOC sentence(s) and returns to departmental custody, he/she shall be treated as a new admission in all respects as outlined in Section (H) of this policy.

VII. ACA STANDARDS: 5-ACI-4A-10, 5-ACI-6A-32, and 4-RH-0010.

VIII. EXPIRATION DATE : January 15, 2024

TENNESSEE DEPARTMENT OF CORRECTION
MENTAL HEALTH SERVICES

TIME	TDOC ID	INMATE LAST NAME	SERVICES CODE	CODES		RETURN FOR SERVICE
				DX Code	Level of Care	
				___ - __		
				___ - __		
				___ - __		
				___ - __		
				___ - __		
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				___ - __		

PROVIDED DIAGNOSIS AND RETURN FOR SERVICE LOG

INSTITUTION

PROVIDER

DATE

TENNESSEE DEPARTMENT OF CORRECTION

PROBLEM ORIENTED – PROGRESS RECORD

INSTITUTION

INMATE NAME: _____ TDOC ID: _____

DATE	TIME	

Do Not Write on Back

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 information
(NAME OF PROVIDER/FACILITY)

indicated below to the Tennessee Department of Correction (TDOC) regarding my clinical treatment.

TDOC Facility Name/Community Supervision Office: _____

Facility Address: _____

Phone Number: _____ Fax Number: _____

☐ I hereby authorize the Tennessee Department of Correction to release clinical information to the persons/entities indicated below for:

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: ____/____/____ thru ____/____/____

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.

Purpose of the 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 Records Management, 2nd Floor, 320 Sixth Avenue North, Nashville, TN 37243-0465.
- I understand that may 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

Duplicate as Needed

TENNESSEE DEPARTMENT OF CORRECTION

ABNORMAL INVOLUNTARY MOVEMENT SCALE

INSTITUTION

INMATE NAME

TDOC ID

INSTRUCTIONS: Rate the highest severity observed. Rate movement occurrences upon activation one *less* than those observed spontaneously.

0 - None **1 - Minimal** **2 - Mild** **3 - Moderate** **4 - Severe**

		CIRCLE ONE
FACIAL & ORAL MOVEMENTS	Muscles of Facial Expression (e.g., movement of forehead, eyebrows, periorbital area, cheeks; including frowning, blinking, smiling grimacing)	0 1 2 3 4
	Lips & Perioral Area (e.g., puckering, pouting, smacking)	0 1 2 3 4
	Jaw (e.g., biting, clenching, chewing, mouth opening, lateral movement)	0 1 2 3 4
	Tongue (e.g., Rate only increase in movement both in and out of mouth)	0 1 2 3 4
EXTREMITY MOVEMENT	Upper (arms, hands, wrists, fingers) Include choleric movement (i.e., rapid objectively purposeless, irregular, spontaneous), atheloid movements (e.g., slow irregular, complex serpentine) Do not include tremor (i.e., repetitive, regular, rhythmic)	0 1 2 3 4
	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	Neck, shoulders, hips (e.g., rocking twisting, squirming, pelvic gyrations)	0 1 2 3 4
GLOBAL JUDGMENT	Severity of Abnormal Movement	0 None, Normal 1 Minimal 2 Mild 3 Moderate 4 Severe
	Incapacitation due to Abnormal Movement	0 None, Normal 1 Minimal 2 Mild 3 Moderate 4 Severe
	Patient's awareness of Abnormal Movements (Rate only patient's report)	0 No Awareness 1 Aware, No Distress 2 Aware, Mild Distress 3 Aware, Moderate Distress 4 Aware, Severe Distress
DENTAL STATUS	Current problems with teeth and/or dentures	0 No 1 Yes
	Does patient usually wear dentures	0 No 1 Yes
	TOTAL	

Mental Health Provider

Date

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 Clinical Alert Log

NAME: _____ TDOC ID: _____ DATE: _____

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

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

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

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

Comments:_____

_____

XI. MENTAL HEALTH TREATMENT HISTORY

☐ **Records Available** ☐ **Records Not Available** ☐ **Records Requested**

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

Last outpatient treatment: ☐ Never Age:_____ # of Sessions: _____ Reason for treatment: _____

Prior outpatient treatment: ☐ Never Age:_____ # of Sessions: _____ Reason for treatment: _____

Prior outpatient facilities: _____

Prior diagnoses: _____

Comments:_____

_____

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

Last inpatient treatment: ☐ Never Age:_____ How long: _____ Reason hospitalized: _____

Last inpatient facility: _____ Number of inpatient stays: _____ Longest stay: _____

Working diagnoses: _____

Age of 1st Psychiatric Hospitalization: _____ Age of Last Psychiatric Hospitalization_____ Age of longest treatment duration:_____

Comments:_____

_____

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

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

_____

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

Current meds intended to treat: _____

Psychotropic meds previously prescribed: _____ ☐ None

_____ ☐ AIMS Completed

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

Age first prescribed meds: _____ Age last prescribed meds: _____ ☐ Arrived on meds Allergies: _____

_____

_____

XII. MENTAL HEALTH DIAGNOSTIC CHECKLIST (To be completed by a licensed mental health professional only)

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

NAME: _____ TDOC ID: _____ DATE: _____

AUDITORY / VISUAL HALLUCINATIONS & DELUSIONS			
☐ **Delusions**: ☐ N/A ☐ Grandiose ☐ Persecutory ☐ Religious ☐ Somatic ☐ Other: _____	☐ **Visual Hallucinations**: ☐ N/A _____ _____	☐ **Auditory Hallucinations**: ☐ N/A _____ _____ Type→	☐ Olfactory ☐ Hostile ☐ Tactile ☐ Demeaning ☐ Threatening ☐ Accusing ☐ Commands to hurt: __Self __Others
OTHER SYMPTOMS & STRESSORS			
☐ Poor appetite ☐ Weight Loss ☐ Eating Disorder	☐ Bizarre Behavior ☐ Fecal / Blood Smearing ☐ Suspected Gender Dysphoria	☐ Stress: Health Concerns ☐ Stress: Family Concerns ☐ Stress: Recent Losses	☐ Stress: Current/Future Sentencing ☐ Other: _____ _____

Comments: _____

_____

_____

XIII. DIAGNOSTIC IMPRESSIONS (DSM-5): (To be completed by a licensed mental health professional only)

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

Comments: _____

_____

_____

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

_____

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

_____

_____

_____

XIV. MENTAL HEALTH TREATMENT RECOMMENDATIONS

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

☐ Inmate refusing mental health services due to: _____

_____

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

_____

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

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

☐ Inmate referred to medical for: _____

☐ Other recommendations/considerations: _____

_____

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