

INMATE MEDICATION/MENTAL HEALTH INFORMATION FORM

INMATE INFORMATION

Full Legal Name of Inmate: _____ DOB: _____ Booking #: _____
Street Address: _____ City: _____ State: _____ Zip Code: _____
If no address on file, is the inmate homeless? Yes _____ No _____ If yes, how long? _____

FAMILY CONTACT INFORMATION

Family Contact Name: _____ Relationship to Inmate: _____
Street Address: _____ City: _____ State: _____ Zip Code: _____
Daytime Phone: _____ Evening Phone: _____ Contact Signature: _____

PSYCHIATRIC/MENTAL HEALTH INFORMATION

Does inmate have any history of psychiatric care? Yes _____ No _____
If yes, name of psychiatrist/therapist/last treatment facility: _____ Date Last Treated: _____
Has inmate been hospitalized for psychiatric care? Yes _____ No _____
If yes, number of hospitalizations: _____ Date Last Treated: _____
Is suicide a concern? Yes _____ No _____ If yes, why? _____

Has the inmate ever attempted suicide? Yes _____ No _____ If yes, date(s) of attempted suicide and method used: _____

Is the inmate currently being treated by an inpatient/outpatient facility? Yes _____ No _____
If yes, name of psychiatrist/therapist/last treatment facility: _____ Date Last Treated: _____

Does the inmate have an AOT (Assisted Outpatient Treatment) Order? Yes _____ No _____

Has the inmate had contact with the ACT (Assertive Community Treatment) team? Yes _____ No _____

Psychiatric Diagnosis: _____

MEDICAL INFORMATION

Medical Doctor's Name: _____ Office Phone: _____

Please list all prescribed medications: _____

Name of Pharmacy: _____ Prior Adverse Medication Effects (i.e. side effects, allergies, poor or alarming results): _____

Has the inmate been taking his/her medications? Yes _____ No _____ If no, time span off medication(s)? _____

Please list any medical concerns: _____

Does the inmate self medicate? Yes _____ No _____ If so, with what? _____

Medical Diagnosis: _____

Is the inmate compliant with mental health/medical treatment plan? Yes _____ No _____

CORRECTIONAL MEDICAL CARE (HEALTH CARE PROVIDER FOR THE DUTCHESS COUNTY JAIL)

FAX (845) 452-5237 OFFICE PHONE (845) 486-3918 (CMC is available 24 hours a day, seven days a week)

(Once faxed please call the office phone and make sure they received and it is legible)

DISCLAIMER: THIS FORM IS PART OF A GUIDE ENTITLED "MY FAMILY MEMBER/FRIEND WITH MENTAL ILLNESS (BRAIN DISORDER) HAS BEEN ARRESTED - WHAT DO I DO?". THE GUIDE IS FOR EDUCATIONAL PURPOSES ONLY AND DOES NOT CONSTITUTE LEGAL ADVICE. THE NAMI VOLUNTEERS AND OTHERS INVOLVED IN DEVELOPING THE GUIDE AND THIS FORM ARE NOT ATTORNEYS. BOTH ARE NOT INTENDED AS A SUBSTITUTE FOR PROFESSIONAL LEGAL ADVICE. PLEASE ASSIST YOUR FAMILY MEMBER/FRIEND WITH OBTAINING PROPER LEGAL REPRESENTATION. Revised 12/2015