### INTERSYSTEM/RESTRICTIVE HOUSING MENTAL HEALTH SCREENING

**INSTRUCTIONS:** This screening shall be completed on all patients arriving from non-DOC facilities or placed in restrictive housing.

<table>
<thead>
<tr>
<th>Date:</th>
<th>Received from:</th>
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<tbody>
<tr>
<td></td>
<td>Out of State</td>
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</tbody>
</table>

1. Have you ever received therapy or medication for a mental health concern and/or suicide attempt? ................................................................. [Yes] [No]
   **(IF YES):** # of inpatient hospitalizations: ________
   Most recent: [Yes] [No]
   **(IF YES) Outpatient:** [Current treatment] [Currently recommended/requird, but not attending]
   Past treatment [Only in correctional settings]
   **(IF YES) Are you taking any medications now?** ................................................................. [Yes] [No]
   **(IF YES) When did you take it last?**

2. Have you ever been told you have a mental health diagnosis? ................................................................. [Yes] [No]
   Reported: [Depression] [Anxiety] [Bipolar] [Schizophrenia] [Psychosis] [ADD/ADHD]
   PTSD [Other (describe): ____________________________]
   VIA: [Indicated from alert received] [Self-report] [Observed ≥ 1 indicators of a mental health problem]

3. Do you feel you need mental health services now? ................................................................. [Yes] [No]
   **(IF YES) Describe:**

4. Have you ever tried to hurt or kill yourself? ................................................................. [Yes] [No]
   **(IF YES): a) How many times? __________ b) When was the last time? __________ c) What happened afterward? [Nothing] [Medically treated] [Psychiatically hospitalized]

5. Have you ever tried to provoke others in an attempt to kill yourself (example, suicide by cop)? .... [Yes] [No]

6. Are you thinking of hurting or killing yourself at this time? ................................................................. [Yes] [No]

7. Have you ever been knocked out for longer than 30 minutes? ................................................................. [Yes] [No]
   **(IF YES) How many times have you been knocked out or lost consciousness?**

8. Clean and sober, have you ever heard or seen things other people did not? ................................................................. [Yes] [No]
   **(IF YES) a) Describe:**
   **(IF YES) b) Do they tell you to hurt yourself or someone else?** ................................................................. [Yes] [No]

9. Were you ever abused at any time in your life, including while in jail or prison? ................................................................. [Yes] [No]
   **(IF YES) Emotionally** [Physically] [Sexually]

10. If you were being pressured, would you have difficulty saying no and walking away? .... [Yes] [No]

11. When is the last time you used alcohol, marijuana, illicit drugs, or abused prescription drugs?
    Substance of choice: ____________________________
    Received chemical dependency treatment? .... [Yes] [No]

12. Do you have trouble reading and writing? ................................................................. [Yes] [No]
    Do you have a history of special education? ................................................................. [Yes] [No]

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### OBSERVATIONS

<table>
<thead>
<tr>
<th>Appearance:</th>
<th>Married</th>
<th>Single</th>
<th>Unmarried</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>[Groomed]</td>
<td>[Disheveled]</td>
<td>[Poor hygiene/malodorous]</td>
</tr>
<tr>
<td>Single</td>
<td>[Poor hygiene/malodorous]</td>
<td>[Groomed]</td>
<td>[Gait]</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Behavior:</th>
</tr>
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<tbody>
<tr>
<td>[Withdrawn/flat affect]</td>
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<tr>
<td>[Inappropriate affect]</td>
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</table>

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<thead>
<tr>
<th>Attitude:</th>
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<tbody>
<tr>
<td>[Easily distracted]</td>
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<tr>
<td>[Cooperative]</td>
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</table>

**DISPOSITION**

<table>
<thead>
<tr>
<th>Housing:</th>
<th>General pop.</th>
<th>COA</th>
<th>RTU/TEC</th>
<th>S code:</th>
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</thead>
</table>

**Referral for mental health appraisal:** [24hr/Urgent] [Routine scheduling] [Priority: ____________]

**Referral for TBI Services** [Notified]

**Housing alert:** [Potential victim (enter into OMNI)] [Notified]

Printed Name: ____________________________
Title: ____________________________
Signature: ____________________________

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State law and/or federal regulations prohibit disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.

**DISTRIBUTION:** Original – Health Record; Copies – Mental Health (2), Reception CUS, SOTP (when applicable)

DOC 13-349 (08/26/2021) DOC 310.150 DOC 320.255 DOC 490.820 DOC 610.040 DOC 630.500 MENTAL HEALTH: Screenings