Department of Corrections
WASHINGTON STATE

PATIENT NAME:	
DOC NUMBER:	DATE OF BIRTH:

INTERSYSTEM/RESTRICTIVE HOUSING MENTAL HEALTH SCREENING ☐ Interpreter needed

INSTRUCTIONS: THIS SCREENING SHALL BE COMPLETED ON ALL PATIENTS ARRIVING FROM NON-DOC FACILITIES OR PLACED IN RESTRICTIVE HOUSING.

DATE:	RECEIVED FROM: ☐ Out of State ☐ Federal Detention ☐ Jail ☐ Other:	RECEIVING FACILITY:

Location of screening: ☐ Confidential office ☐ Other:

Inform patient: We want to make sure we are providing for your mental health and psychiatric needs while you are with DOC. The more accurate the information you provide, the better we will be at making sure those needs are met. If you don't understand a question, please let me know. We ask these questions of everyone who comes to DOC. I will start by asking about your preferred pronouns. Please know that our mental health and psychiatry staff will do our best to follow your stated preference and we will make this information available to other healthcare providers. This information will not be share outside of Health Services. If you wish others to use your preferred pronouns, please let your Classification Counselor know.

Pronouns used: ☐ She/her ☐ He/him ☐ They/them ☐ No pronouns, use my name ☐ Other:

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: _____
   (IF YES) Outpatient: ☐Current treatment ☐Currently recommended/required, but not attending ☐Past treatment ☐Only in correctional settings
   13-035 Authorization for Disclosure of Health Information signed..... ☐Yes ☐No
   (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
3. Do you feel you need mental health services now?..... ☐Yes ☐No
   (IF YES) Describe:
4. Have you ever self-injured to cope with emotional pain, cope with trauma, or to avoid suicide?..... ☐Yes ☐No
   (IF YES): a) How many times? _____ b) How/When was the last time? _____
   c) What happened afterward? ☐Nothing ☐Medically treated ☐Psychiatrically hospitalized
   d) Any therapy for this? ☐No ☐Yes – What kind?
5. Have you ever tried to kill yourself/end your life? ..... ☐Yes ☐No
   (IF YES): a) How many times? _____ b) When was the last time? _____
   c) What happened afterward? ☐Nothing ☐Medically treated ☐Psychiatrically hospitalized
   d) Any therapy for this? ☐No ☐Yes – What kind?
6. Have you ever tried to provoke others in an attempt to kill yourself (for example, suicide by cop)? ☐Yes ☐No
7. Are you thinking of hurting or killing yourself at this time?..... ☐Yes ☐No
8. Have you ever lost consciousness for more than 30 minutes, such as in a car accident, after a fall, or after a fight between you and someone else (including DV/IPV)?..... ☐Yes ☐No
   (IF YES) How many times have you been knocked out or lost consciousness? (Refer for TBI services)
9. 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
10. Have you experience trauma in your life?..... ☐Yes ☐No
11. If you were being pressured, would you have difficulty saying no and walking away? ..... ☐Yes ☐No
12. When is the last time you used alcohol, marijuana, illicit drugs, or abused prescription drugs? _____
    Substance of choice? Received substance use disorder ☐Yes ☐No

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13. Do you have trouble reading and writing? ☐Yes ☐No
    Do you have a history of special education? ☐Yes ☐No
14. Do you have a legal guardian, Durable Power of Attorney for Healthcare, or Power of Attorney? ☐Yes ☐No
    (IF YES): Type: _____ Name: _____
    Contact information: _____
    _____
    Did you complete a medical or mental health advance directive in the community? ☐Yes ☐No

OBSERVATIONS

Appearance:	☐Alert/oriented	☐Disoriented/confused	☐Gait
	☐Groomed	☐Disheveled	☐Poor hygiene/malodorous
	☐Scars/tattoos	☐Poor dentition	☐Other:
Behavior:	☐Unremarkable	☐Odd/bizarre	☐Fidgety/antsy
	☐Withdrawn/flat affect	☐Inappropriate affect	☐Slow to respond
	☐Rapid/pressured speech	☐Tremors	☐Other:
Attitude:	☐Cooperative	☐Easily distracted	☐Suspicious
	☐Anxious	☐Hostile/defensive	☐Manipulative
	☐Tangential	☐Evasive/guarded	☐Other:

DISPOSITION

Housing:	☐ General population	☐ COA	☐ RTU/TEC	S code:
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:

SECONDARY SCREEN/RECORDS REVIEW TO BE COMPLETED UPON ADMISSION TO DOC

If readmit, previous S code: _____ Date of last S code assignment: _____

Psychiatric medication confirmed from jail? ☐Yes ☐No

(IF YES) What psychiatric medications: _____

Available records reviewed? ☐Yes ☐No

☐ Community MH _____

☐ State Hospital _____

☐ Other _____

S code provisional:	S code final:	G code:	B code:

Printed Name	Title:	Signature:	Date:

Distribution: **ORIGINAL** – Health Record **COPY** – Mental Health (2), Reception CUS, SOTAP (when applicable)