Department of Corrections
WASHINGTON STATE

REQUEST FOR MENTAL HEALTH ASSESSMENT

INDIVIDUAL'S NAME (Last, First):	DOC NUMBER:	FACILITY:

PART 1 – REQUEST FOR MENTAL HEALTH ASSESSMENT

Reason for requesting assessment (observations, incarcerated individual's statements/behavior):

REQUESTING EMPLOYEE/CONTRACT STAFF	TITLE	DATE

PART 2 – MENTAL HEALTH FINDINGS (If received from Custody, enter a Comment chrono documenting that there was a response to this request)

Date Seen:

Disposition

Mental Health Appraisal or Mental Health Update needed: ☐ Yes ☐ No

If yes: ☐ Urgent – within 24 hours ☐ Routine – Priority (1-3):

Treatment Needs (check all that apply)

☐ Referral to primary therapist for follow-up
☐ Referral to psychiatric prescriber for follow-up
☐ Referral to supervising psychologist, _____, for possible assignment for crisis/solution therapy
☐ Referral to IMU MH, _____, for possible Behavior Management Plan
☐ Other treatment needs: _____
☐ No mental health treatment needs at this time

Housing Considerations (check all that apply)

☐ No alternate housing needs at this time
☐ Emergent move to COA
☐ Urgent transfer to another facility for MH reasons indicated
☐ Urgent referral to Residential Treatment Unit indicated
☐ Routine referral to Residential Treatment Unit indicated
☐ Other housing considerations:

Housing Unit Supervisor alert needed? ☐ Yes ☐ No

If yes: ☐ Potential victim (enter into OMNI-HS) ☐ Potential predator (enter into OMNI-HS)

Notified _____ to make appropriate cell assignment.

ASSESSING MENTAL HEALTH PROVIDER SIGNATURE AND STAMP	TITLE	DATE

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.