Department of Corrections
WASHINGTON STATE

PATIENT I.D. DATA:
(Name, DOC#, DOB)

MENTAL HEALTH TRANSFER SCREENING

FACILITY	DATE

Instructions: Complete this form according to the Mental Health Transfer Protocol on all patients prior to transfer in or out of a residential treatment unit (RTU) and all patients with a PULHES "S" code of 3 or greater prior to transfer to another DOC facility. **Transfers to segregation or Intensive Management Units (IMU) are exempt.**

INTENDED TRANSFER DESTINATION	CUSTODY LEVEL OF SETTING	TYPE OF SETTING ☐ RTU ☐ GP
REASON PATIENT IS BEING TRANSFERED		

Section 1

Psychiatric prescriber is responsible for completion of this section; Pharmacy and/or Nursing staff may assist

1. Psychotropic medications have been added or discontinued in last 90 days ..... ☐ Yes ☐ No
   If medications have been changed, the date was: _____
2. Psychotropic medication dosages have changed in last 30 days ..... ☐ Yes ☐ No
   If the dosage has been changed, the date was: _____
3. The patient has had minimal or no symptoms for 30 days. If "No", describe below under "Additional Comments" ..... ☐ Yes ☐ No
4. The patient is on involuntary medications ..... ☐ Yes ☐ No
   If on involuntary medications, order expires: _____
5. Psychotropic meds are/could be KOP (verify accuracy of PULHES U code) ..... ☐ Yes ☐ No
6. The patient is at risk of danger to self (DTS). If "Yes", describe below under "Staff Alerts" ..... ☐ Yes ☐ No
7. The patient is a danger to others (DTO). If "Yes", describe below under "Staff Alerts" ..... ☐ Yes ☐ No

Current medications (list all medications, doses, and schedule):

Staff Alerts (If DTS, indicate suicidality and/or nature of danger to self risk and imminence. If DTO, indicate pattern, any potential targets, and imminence. Indicate any other alerts):

Additional comments:

Cleared for transfer: ☐ Yes ☐ No ☐ Further evaluation needed

_____ _____
STAMP/PRINTED NAME and SIGNATURE of PSYCHIATRIC PRESCRIBER DATE

Section 2

To be completed by primary therapist, reviewed and approved by supervising psychologist

8. The patient is participating in treatment ..... ☐ Yes ☐ No

Department of Corrections
WASHINGTON STATE

PATIENT I.D. DATA:
(Name, DOC#, DOB)

MENTAL HEALTH TRANSFER SCREENING

FACILITY	DATE

9. The patient has a clear understanding of his/her relapse pattern(s). If "No", describe below under "Additional Comments") ☐ Yes ☐ No
10. The patient is at risk of danger to self (DTS). If "Yes", describe below under "Staff Alerts" ☐ Yes ☐ No
11. The patient is a danger to others (DTO). If "Yes", describe below under "Staff Alerts" ☐ Yes ☐ No
12. The patient's mental health needs can be met at:
    a) Reentry center (consider the patient's ability to obtain medications) ☐ Yes ☐ No
    b) Camp (excluding MCC-MSU-MHU) ☐ Yes ☐ No
    c) Major facility general population (GP) ☐ Yes ☐ No
    d) MCC-MSU-MHU ☐ Yes ☐ No
    e) Another RTU ☐ Yes ☐ No

Staff Alerts (If DTS, indicate suicidality and/or nature of danger to self risk and imminence; if DTO, indicate pattern, any potential targets, and imminence; indicate any other alerts):

Custody has been informed of any DTS/DTO alerts: ☐ Yes ☐ No

Additional comments:

Cleared for transfer: ☐ Yes ☐ No ☐ Further evaluation needed

STAMP/PRINTED NAME and SIGNATURE of SUPERVISING PSYCHOLOGIST _____ DATE _____

Section 3

To be completed by facility mental health lead

Mental health lead at receiving facility gave verbal approval for transfer: ☐ Yes ☐ No Date: _____

Name of receiving mental health lead: _____

Complete the following if the receiving facility declines transfer:

Reasons for denial if declined:

Appealed by referring Facility? ☐ Yes ☐ No

If yes, decision made by Headquarters Mental Health Administrator on appeal:

☐ Cleared for transfer ☐ Not cleared for transfer

STAMP/PRINTED NAME and SIGNATURE of MENTAL HEALTH LEAD _____ DATE _____

Note: All three sections must be signed prior to distributing

Department of Corrections
WASHINGTON STATE

PATIENT I.D. DATA:

(Name, DOC#, DOB)

MENTAL HEALTH TRANSFER SCREENING

FACILITY	DATE

Distribution: Original – Health Record Copy – Case Manager