



PATIENT NAME: Last name, First name	
DOC NUMBER: DOC #	DATE OF BIRTH: DOB

MENTAL HEALTH UPDATE AND TREATMENT PLAN

DATE Date	FACILITY Select	UNIT (optional)
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Interpreter used

SECTION 1 – Copy to be given to patient

Reason for report (check one): New to institution Annual update
 Other (specify):

Engagement with Mental Health Services this past year:

- Case Management:
- Group Treatment:
- Individual Therapy:
- Current Psychotropic Medications:

Clinician perspective on progress, treatment, and functioning:

Click to enter text.

Patient perspective on progress:

Click to enter text.

Treatment Goal(s) in collaboration with the patient for the next 12 months:

Click to enter text.

Level of Care:

Click to enter text.

Residential Treatment:

General Population and Outpatient Services:

- Level 1 or 2 diagnosis that meets criteria for medically necessary treatment in an outpatient setting.
- Case Management :
- Group Treatment:
- Individual Therapy:

No mental health services indicated per WA DOC Health Plan.

Patient signature: _____

Date: _____

Therapist: Click to enter name, Click to enter title



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Signature

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SECTION 2 – Current Clinical Presentation

Observations and Mental Status

Appearance <input type="checkbox"/> Groomed <input type="checkbox"/> Disheveled <input type="checkbox"/> Poor Hygiene <input type="checkbox"/> Malodorous <input type="checkbox"/> Poor Dentition <input type="checkbox"/> Scars/Tattoos <input type="checkbox"/> Other:	Alertness <input type="checkbox"/> Alert <input type="checkbox"/> Somnolent/sedated <input type="checkbox"/> Other: Orientation <input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time <input type="checkbox"/> Situation <input type="checkbox"/> Other:	Psychomotor <input type="checkbox"/> Within normal limits <input type="checkbox"/> Tremor <input type="checkbox"/> Fidgety <input type="checkbox"/> Catatonic <input type="checkbox"/> Agitated <input type="checkbox"/> Slowed <input type="checkbox"/> Posturing, stereotyped movements <input type="checkbox"/> Other:	Interactional Style <input type="checkbox"/> Pleasant/Cooperative <input type="checkbox"/> Suspicious <input type="checkbox"/> Evasive/Guarded <input type="checkbox"/> Hostile/Aggressive <input type="checkbox"/> Urgency <input type="checkbox"/> Aggravated <input type="checkbox"/> Manipulative <input type="checkbox"/> Withdrawn <input type="checkbox"/> Other:
Affect-Visible <input type="checkbox"/> Euthymic <input type="checkbox"/> Labile <input type="checkbox"/> Inappropriate <input type="checkbox"/> Constricted <input type="checkbox"/> Flat or blunted <input type="checkbox"/> Irritable <input type="checkbox"/> Expansive or euphoric <input type="checkbox"/> Angry <input type="checkbox"/> Dysthymic/sad <input type="checkbox"/> Other:	Mood (self-report) <input type="checkbox"/> Euthymic <input type="checkbox"/> Dysthymic/sad <input type="checkbox"/> Depressed <input type="checkbox"/> Anxious/worried <input type="checkbox"/> Angry <input type="checkbox"/> Hypomanic/manic <input type="checkbox"/> Other:	Speech <input type="checkbox"/> Appropriate <input type="checkbox"/> Slurred or dysarthric <input type="checkbox"/> Limited production <input type="checkbox"/> Loud <input type="checkbox"/> Rapid <input type="checkbox"/> Pressured <input type="checkbox"/> Soft <input type="checkbox"/> Slow <input type="checkbox"/> Lags or latency <input type="checkbox"/> Neologisms <input type="checkbox"/> Other:	Hallucinations Self-Report: <input type="checkbox"/> None <input type="checkbox"/> Hallucinations: <input type="checkbox"/> Other sensory abnormality: Observed: <input type="checkbox"/> Does not appear to be responding to internal stimuli <input type="checkbox"/> Appears to be responding to internal stimuli <input type="checkbox"/> Other:
Thought Process <input type="checkbox"/> Organized <input type="checkbox"/> Tangential <input type="checkbox"/> Loose associations <input type="checkbox"/> Poverty of content <input type="checkbox"/> Flight of ideas <input type="checkbox"/> Racing thoughts <input type="checkbox"/> Blocking <input type="checkbox"/> Perseverative <input type="checkbox"/> Other:	Thought Content <input type="checkbox"/> Within normal limits <input type="checkbox"/> Delusions: <input type="checkbox"/> Hopeless/Helpless <input type="checkbox"/> Obsessions: <input type="checkbox"/> Paranoia <input type="checkbox"/> Phobias <input type="checkbox"/> Preoccupation: <input type="checkbox"/> Other:	Attention Impairment Observed <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Waxing and waning <input type="checkbox"/> Other:	Memory Impairment Observed <input type="checkbox"/> None <input type="checkbox"/> Immediate recall <input type="checkbox"/> Short-term <input type="checkbox"/> Long-term



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Comments on Observations and Mental Status:

Daily Functioning (describe):

Sleep:

Appetite:

Weight:

Energy:

- Medication non-compliance:
- Misuse of substances:
- Missing commitments:
- Interpersonal functioning:

Traumatic/Non-traumatic Brain Injury

- No
- Yes:

Information for Referral to TBI Program

- a) When thinking about any injuries you have had to your head or neck, how many times have you been dazed and confused?
- b) How many times have you been knocked out or lost consciousness?

Medical conditions that may have an impact on mental health symptoms:

Seizure history:

- No
- Yes:

Harm to self/other:

Suicide Screening/ASQ (NIMH, 07/01/2020):

- 1. In the past few weeks, have you wished you were dead? No Yes
- 2. In the past few weeks, have you felt that you or your family would be better off if you were dead? No Yes
- 3. In the past week, have you been having thoughts about killing yourself? No Yes
- 4. Have you ever tried to kill yourself? No Yes



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- 5. Are you having thoughts of killing yourself right now? No Yes
- 6. Do you feel connected to anyone in your life? No Yes
- 7. Do you feel like there are people who care about you and you can turn to in times of need? No Yes

If patient answered **Yes** to any of questions 1 through 5, complete 13-371 Suicide Risk Assessment **and** 13-527 Mental Health Safety Plan.

- Patient has suicide risk assessment and safety plan; no changes needed.
Date current 13-371 completed: _____ Date current 13-527 completed: _____
- Self-harm behavior:
- Harm to others:

Current psychotropic medications: No Yes (listed below)

Medication prescribed:	Taken consistently	Taken inconsistently	Declined	Pill line	Keep on person
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Response to psychotropic medications since last appraisal or update:

Case conceptualization and diagnostic rationale:

DSM-5 Diagnoses:

General dynamic risk assessment:

- Level of insight: Low Moderate High
- Criminal attitudes: Low Moderate High
- Impulsivity: Low Moderate High



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WSDOC Global Assessment of Functioning (GAF):

- 100-91 Superior – Able to function and program in all prison settings with no special supports.
- 90-81 Minimal symptoms – Able to function and program in all prison settings with occasional informal support.
- 80-71 Transient symptoms – Able to function and program in all prison settings with informal support. Occasional minor infractions that may, or may not, be related to symptoms.
- 70-61 Mild or some difficulty – May need periodic or regular formal support (case management) and/or treatment in GP setting. Symptoms may interfere with programming and be related to minor behavioral problems. Generally, would not qualify for medical necessity for treatment based on functional limitations.
- 60-51 Moderate symptoms – Needs regular support (case management) and/or treatment in GP setting, rarely in a residential setting. Symptoms affect programming and behavior but are manageable with treatment and/or supports.
- 50-41 Serious symptoms – Needs regular formal support and treatment in GP setting; likely to need a residential setting. Symptoms affect programming and behavior in ways that limit access to programs and are likely to affect safety and security.
- 40-31 Reality testing/communication/several areas impaired – Needs residential treatment. Symptoms likely to prevent programming other than highly structured MH programming. Behavioral problems related to symptoms regularly observed. ADLs generally intact but may need support.
- 30-21 Delusions/hallucinations/impaired communication – Needs acute/intermediate residential treatment. Symptoms substantially affect programming and/or safety and security. ADLs likely compromised.
- 20-11 Danger of hurting self/minimal hygiene/grossly impaired communication – Needs acute residential treatment. Active danger to self/others or gravely disabled due to mental illness and may need restraint or COA placement. Unable to safely manage ADLs independently.
- 10-1 Persistent danger of severely hurting self or others, persistent lack of self-care – Likely to need restraint or COA placement. Full care.

Referrals:

- Referral to Psychiatry:
 Clinician referred to:
 Reason:
 Date of referral:
 Emergent (see within 7-14 days)
 Urgent (see within 30 days)
 Routine (see within 60 days)
- Referral for Psychological Testing:
 Clinician referred to:
 Reason:
 Date of referral:



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- Referral to TBI Program:
Clinician referred to:
Reason:
Date of referral:

- Camp screening, if applicable:** Current mental health evaluation reflects a GAF of 61 or more.
- Patient has not committed any self-destructive acts for over one year.
 - Patient's mental health needs can be met at camp where mental health staff are onsite but there is no psychiatric prescriber onsite.
 - Mental health issues do not interfere with living under camp circumstances.
 - Additional information/comments:

Classification information:

Custody level: Choose an item. S code: Choose an item. Choose an item.:

Report by: [Click to enter name](#), [Click to enter title](#)

Signature	Date
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