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|  | BEHAVIORAL HEALTH ADMINISTRATION (BHA)OUTPATIENT COMPETENCY RESTORATION PROGRAM (OCRP)**Weekly Status Update** | Day No.       of order |
| **Identifying Information** |
| PERSON’S NAME      | CAUSE NUMBER(S)      |
| OCRP PROVIDER      | OCR ORDER END DATE      | LENGTH OF ORDER      |
| FORENSIC NAVIGATOR’S NAME      | CURRENT ADDRESS      |
| RESIDENTIAL SETTING TYPE | OUTPATIENT BEHAVIORAL HEALTH PROVIDER AND MCO      |
| FHARPS[ ]  Yes[ ]  No | IF YES, FHARPS PROVIDER’S NAME      | FPATH[ ]  Yes[ ]  No | IF YES, FPATH PROVIDER’S NAME      |
| **Identified Barriers to Competency - Summary** |
| The symptoms below are from the Forensic Competency Evaluation and are identified as interfering with the person’s competency. New symptoms may have been identified through the course of the OCRP and should also be reflected below. |
| DESCRIPTION OF IDENTIFIED SYMPTOMS UNDERLYING PERSON’S BARRIERS TO COMPETENCY | PROGRESS? | SYMPTOM PROGRESS UPDATE | CLINICIAN-RELATED DIMENTIONS OF PSYCHOSIS SYMPTOM SEVERITY (1 – 5) |
| YES | NO |
|       | [ ]  | [ ]  |       |       |
|       | [ ]  | [ ]  |       |       |
|       | [ ]  | [ ]  |       |       |
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|       | [ ]  | [ ]  |       |       |
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|       | [ ]  | [ ]  |       |       |
| **Compliance Summary** |
| ATTENDANCE COMPLIANT[ ]  Yes [ ]  No [ ]  N/A due to LOA Summary sectionPLEASE LIST MISSED SESSIONS:      | MEDICATION COMPLIANT[ ]  Yes [ ]  No [ ]  N/APLEASE DESCRIBE:      |
| BEHAVIORAL HEALTH TREATMENT COMPLIANT[ ]  Yes [ ]  No [ ]  N/APLEASE DESCRIBE:      | SUD TREATMENT COMPLIANT[ ]  Yes [ ]  No [ ]  N/APLEASE DESCRIBE:      |
| **Leave of Absence (LOA) Summary** |
| Currently on a Leave of Absence: [ ]  Yes [ ]  No If yes, start date and reason:      Please list all previous LOA(s):[ ]  N/A or       |
| **Competency Evaluation Request Summary** |
| Request for early evaluation? [ ]  Yes [ ]  No If yes, date of early evaluation:      Basis of request for early evaluation: [ ]  Believed to be not restorable [ ]  Believed to be competentCompetency re-evaluation request date:       Competency re-evaluation completion date:       |
| **Summary Narrative** |
| [ ]  This person is on a Leave of Absence from OCRP. Please see the Leave of Absence (LOA) Summary section above for additional information. No Summary Narrative will be provided.      |
| This person has actively participated in       days of OCRP treatment. |
| PERSON COMPLETING FORM DATE FORM COMPLETED            |