|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | BEHAVIORAL HEALTH ADMINISTRATION (BHA)  **Forensic (6358) Consultation** | | | | | | | | |
| PATIENT’S NAME | | | | MR NUMBER | | | ADMISSION DATE | | | DOC NUMBER |
| DATE OF BIRTH | | | WARD | | | | DATE OF PRESENT REFERRAL FOR 6358 EVALUATION | | | |
|  | | | | | | | | | | |
| **A.1.** | COUNTY / MCO | | MENTAL HEALTH LIAISON | | | | PHONE | | | ANTICIPATED DISCHARGE DATE |
| **A.2.** | PRINCIPLE CLINICAL CHALLENGES POSED DURING THE DURRENT ADMISSION | | | | | | | | | |
| CURRENT NEEDS / LEVEL OF FUNCTIONING | | | | | | | | | |
| **A.3.** | PROPOSED DISCHARGE PLACEMENT / PLAN | | | | | | | | | |
| Is a less restrictive order planned:  Yes  No | | | | | | | | | |
| **A.4.** | Patient admitted from:  Jail  CFS  Prison  Other: | | | | | | | | | |
| **A.5.** | Check if patient is under the authority of (review of the State Hospital / DOC database indicate):  The Department of Corrections (DOC); if checked, complete the following. | | | | | | | | | |
| Date reviewer contacted Corrections staff (CCO) for consultation:  Results: | | | | | | | | | |
| Date reviewer contacted Chemical Dependency staff or consultation:  Results: | | | | | | | | | |
| AGENCY NAME | | | | CCO | | | | PHONE | |
| The Indeterminate Sentence Review Board; if checked, complete the following. | | | | | | | | | |
| CONTACT / LOCATION | | | | | | | | PHONE | |
| **A.6.** | Court ordered Chemical Dependency Treatment:  Yes  No Date confirmed: | | | | | | | | | |
| CONTRACT’S NAME | | | | | | | | PHONE | |
| SOCIAL WORKER’S NAME | | | | | | | | | PHONE INCLUDED EXTENTION | |
| **B.** | **Discharge Review Summary** | | | | | | | | | |
| REASONS FOR CURRENT HOSPITALIZATIONS / PERIOD OF EVALUATION | | | | | | | | | |
| COMPETENCE EVALUATION(S) | | | | | | | | | |
| RELEVANT CLINICAL HISTORY | | | | | | | | | |
| LEGAL | | | | | | | | | |
| PREVIOUS FORENSIC EVALUATIONS | | | | | | | | | |
| CURRENT HOSPITALIZATION AND RESPONSE TO TREATMENT | | | | | | | | | |
| MSE: | | | | | | | | | |
| **C.** | Impressions / Recs: | | | | | | | | | |
| Treatment Team members consulted: | | | | | | | | | |
| REVIEWER’S SIGNATURE (LICENSED PSYCHOLOGIST AND FORENSIC (6358) CONSULTANT) DATE | | | | | | | | | |
| REVIEWER’S PRINTED NAME | | | | | PHONE | | | | |
| DATE OF DISCHARGE REVIEW | | | | | | | | | |
| Treatment Team member(s) attending (name and title for each): | | | | | | | | | |
| Results: (i.e., likelihood of harm as a result of mental disorder; discharge status; no discharge, discharge with an LRA / CR order and conditions, discharge without an LRA / CR order; and discharge placement; corrections facility (name), assisted living facility of any kind (name), or independent living) | | | | | | | | | |
| PSYCHIATRIST’S SIGNATURE DATE | | | | | | | PRINTED NAME HERE | | |
| PSYCHOLOGIST’S SIGNATURE DATE | | | | | | | PRINTED NAME HERE | | |
| SOCIAL WORKER’S SIGNATURE DATE | | | | | | | PRINTED NAME HERE | | |
| Patient is being returned to a correctional facility.  Date correctional facility notified:  Person contacted:  Patient is not being returned to a correctional facility. | | | | | | | | | |