Department of Corrections
WASHINGTON STATE

PATIENT NAME:	
DOC NUMBER:	DATE OF BIRTH :

INTERSYSTEM/RESTRICTIVE HOUSING MENTAL HEALTH SCREENING ☐ Interpreter needed

INSTRUCTIONS: THIS SCREENING SHALL BE COMPLETED ON ALL PATIENTS ARRIVING FROM NON-DOC FACILITIES OR PLACED IN RESTRICTIVE HOUSING.

DATE:	RECEIVED FROM: ☐ Out of State ☐ Federal Detention ☐ Jail ☐ Other:	RECEIVING FACILITY:

1. Have you ever received therapy or medication for a mental health concern and/or suicide attempt? ..... ☐Yes ☐No
   (IF YES): # of inpatient hospitalizations: _____ Most recent: _____
   (IF YES) Outpatient: ☐Current treatment ☐Currently recommended/required, but not attending ☐Past treatment ☐Only in correctional settings
   (IF YES) Are you taking any medications now? ..... ☐Yes ☐No
   (IF YES) When did you take it last?
2. Have you ever been told you have a mental health diagnosis? ..... ☐Yes ☐No
   Reported: ☐Depression ☐Anxiety ☐Bipolar ☐Schizophrenia ☐Psychosis ☐ADD/ADHD ☐PTSD ☐Other (describe): _____
   Via: ☐Indicated from alert received ☐Self-report ☐Observed ≥ 1 indicators of a mental health problem
3. Do you feel you need mental health services now? ..... ☐Yes ☐No
   (IF YES) Describe:
4. Have you ever tried to hurt or kill yourself? ..... ☐Yes ☐No
   (IF YES): a) How many times? _____ b) When was the last time? _____
   c) What happened afterward? ☐ Nothing ☐ Medically treated ☐ Psychiatrically hospitalized
5. Have you ever tried to provoke others in an attempt to kill yourself (example, suicide by cop)? .... ☐Yes ☐No
6. Are you thinking of hurting or killing yourself at this time? ..... ☐Yes ☐No
7. Have you ever been knocked out for longer than 30 minutes? ..... ☐Yes ☐No
   (IF YES) How many times have you been knocked out or lost consciousness? (Refer for TBI services)
8. Clean and sober, have you ever heard or seen things other people did not? ..... ☐Yes ☐No
   (IF YES) a) Describe: _____
   (IF YES) b) Do they tell you to hurt yourself or someone else? ..... ☐Yes ☐No
9. Were you ever abused at any time in your life, including while in jail or prison? ..... ☐Yes ☐No
   (IF YES) ☐ Emotionally ☐ Physically ☐ Sexually
10. If you were being pressured, would you have difficulty saying no and walking away? ..... ☐Yes ☐No
11. When is the last time you used alcohol, marijuana, illicit drugs, or abused prescription drugs? _____
    Substance of choice: Received chemical dependency treatment? ... ☐Yes ☐No
12. Do you have trouble reading and writing? ..... ☐Yes ☐No
    Do you have a history of special education? ..... ☐Yes ☐No

OBSERVATIONS				
Appearance:	☐Groomed	☐Disheveled	☐Poor hygiene/malodorous	☐Gait
☐Alert/oriented	☐Disoriented/confused	☐Scars/tattoos	☐Poor dentition	☐Other:
Behavior:	☐Withdrawn/flat affect	☐Odd/bizarre	☐Fidgety/antsy	☐Slow to respond
☐Unremarkable	☐Inappropriate affect	☐Tremors	☐Rapid/pressured speech	☐Other:
Attitude:	☐Easily distracted	☐Suspicious	☐Anxious	☐Hostile/defensive
☐Cooperative	☐Manipulative	☐Tangential	☐Evasive/guarded	☐Other:

DISPOSITION	**Housing**: ☐ General pop.	☐ COA	☐ RTU/TEC	S code:
Referral for mental health appraisal:	☐ 24hr/Urgent	☐ Routine scheduling		Priority:
☐ **Referral for TBI Services**	Notified			
☐ **Housing alert:** Potential victim (enter into OMNI)	Notified			

Printed Name:	Title:	Signature:

DISTRIBUTION: Original – Health Record; Copies – Mental Health (2), Reception CUS, SOTP (when applicable)