Department of Corrections
WASHINGTON STATE

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

MENTAL HEALTH GROUP NOTE

DATE	TIME	FACILITY	UNIT (optional)	GROUP

PARTICIPATION

☐ High ☐ Moderate ☐ Low ☐ None ☐ Focused ☐ Attentive ☐ Distracted ☐ Disruptive

NARRATIVE

NAME AND TITLE OF CLINICIAN:	SIGNATURE OF CLINICIAN: