Department of Corrections
WASHINGTON STATE

PATIENT I.D. DATA:

(Name, DOC#, DOB)

FACILITY: _____

CONDITIONS OF CONFINEMENT – MENTAL HEALTH

DATE: _____ TIME: _____

Reason(s) for conditions: ☐ Suicide attempt ☐ Self-harm attempt ☐ Risk of suicide ☐ Other (specify): _____
☐ Risk of self-harm ☐ Severe psychiatric decompensation

Describe:

Observation Assignment	
☐ **Continuous observation** watch	☐ **30 minute** safety checks
☐ **15 minute** safety checks	☐ Other:

Allowable In-Cell Property		
☐ 1 Smock	☐ Mattress	☐ Glasses
☐ 1 White top	☐ 1 Sleeping bag	☐ Soap
☐ 1 Shirt	☐ Pillow x 0	☐ Toothbrush & paste
☐ 1 Pair of shorts	☐ Blanket x 0	☐ Fingerbrush & paste
☐ Socks	☐ Security blanket	☐ Flex pen/crayon & paper
☐ Coveralls	☐ Soft-covered book x 0	
☐ Other:		

Modification to Diet	Allowable Activities
☐ Sack meals / Clamshell	☐ Shower frequency:
☐ No Utensils	☐ Hygiene items allowed
☐ No Bones	☐ Yard/Day Room time by custody level
☐ No Plastic	☐ Other:
☐ No Sharps	
☐ Regular Tray	
☐ Return utensils to staff	
☐ Other:	

The above noted modifications will end at _____ on _____

Conditions approved by:

_____	_____	_____
Mental Healthcare Provider/Title	Signature	Date / Time
_____	_____	_____
Employee receiving telephone approval (after hours only)	Signature	Date / Time

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