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

Department of Corrections
WASHINGTON STATE

MENTAL HEALTH ENCOUNTER REPORT

DATE	TIME	FACILITY	UNIT (optional)

Subjective Complaint/Objective Findings/Assessment/Evaluation:
Reason for encounter:

Diagnosis/Plan/Rx: (Diagnosis required for medication orders. Allergies required for new medication orders.)

☐ Risks/benefits of recommended intervention explained; patient consents.

Name and Title of Employee/Contract Staff Performing Encounter:	Signature: