

Inmate Mental Health Information Form

INMATE INFORMATION

FULL LEGAL NAME OF INMATE: _____

STREET ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

DOB: _____ BOOKING # (PFN): _____

JAIL LOCATION: SANTA RITA _____ GDDF _____ HOUSING UNIT#: _____

FAMILY CONTACT INFORMATION

FAMILY CONTACT NAME: _____ RELATIONSHIP _____

STREET ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

DAYTIME PHONE: _____ EVENING PHONE: _____

CONTACT SIGNATURE: x _____

PSYCHIATRIST/TREATMENT FACILITY INFORMATION

PSYCHIATRIST/LAST TREATMENT FACILITY: _____ DATE LAST TREATED: _____

STREET ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

PHONE: _____ FAX: _____

PHARMACY _____ FAX _____ PHONE _____

MENTAL HEALTH INFORMATION

DIAGNOSIS: _____

DAYTIME MEDICATIONS: _____

NIGHTTIME MEDICATIONS: _____

PRIOR ADVERSE MEDICATION EFFECTS (i.e. side effects, allergies, poor efficacy): _____

IS SUICIDE OR VIOLENCE A CONCERN? NO ___ YES ___ IF YES, WHY? _____

MEDICAL CONDITIONS / CONCERNS: ADDITIONAL MENTAL HEALTH HISTORY _____

MEDICAL DOCTOR'S NAME: _____ OFFICE PHONE: _____

STREET ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

JAIL MENTAL HEALTH SERVICES (CJMH) FAX NUMBER

925-551-6504