## INMATE MENTAL HEALTH INFORMATION FORM

Print Clearly & Use Reverse Side As Needed

## **INMATE INFORMATION**

Inmate's Full Legal Name:		
Date Of Birth: Booking #		
SOURCE OF INFORMATION FOR THIS FORM Your Name:		
Relationship: Professional Family Friend ( Daytime Phone:	•	·
SIGN HERE:		
TREATMENT HISTORY BY MARIN		HEALTH SERVICES (CMHS)
Presently CMHS Client: Yes No Unk		,
Last CMHS Clinic		
PSYCHIATRIST/TREATMENT F.  ( Check here if using reverse side for more Name: Phone:	e than one provider) Date Last Tre	ated:
PHARMACY Name:	Phone:	Fax:
MENTAL HEALTH INFORMATION  Diagnoses:		
Current Medications (Name, Dosage, Frequenc	y & Date Started):	
Last Time Medications Taken (if known): Date:_ Medication Compliance? Yes No Adverse Effects of Medications (i.e. side effects	Partial	
Prior Helpful Medications? Why Discontinued?		
Is Suicide a Concern? No Yes If yes, w	hy? (include prior attempts)	
Other medical conditions including a	llergies, or additional n	nental health information:
MEDICAL DOCTOR Name:		
Check here if CONFIDENTIALITY V	VAIVER BY INMATE acco	mpanies this form

MARIN COUNTY JAIL CONTACT INFORMATION

Fax, mail, or hand deliver this form to: Mental Health Staff Fax: 415-473-2399

Address: Marin County Jail, Marin County Medical Jail Services. 13 Peter Behr Rd, San Rafael, CA 94903

Phone: 415-499-6291