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 ___ Other ___ (Describe :_____)

Daytime Phone: _____ Evening Phone: _____

SIGN HERE: _____

TREATMENT HISTORY BY MARIN COMMUNITY MENTAL HEALTH SERVICES (CMHS)

Presently CMHS Client: Yes ____ No ____ Unknown ____ Date Last Treated: _____

Last CMHS Clinic _____ Last CMHS Doctor_____

PSYCHIATRIST/TREATMENT FACILITY/OTHER MENTAL HEALTH PROVIDERS

(____ Check here if using reverse side for more than one provider).

Name: _____ Date Last Treated: _____

Phone: _____Fax: _____

PHARMACY Name: _____ Phone: _____ Fax: _____

MENTAL HEALTH INFORMATION

Diagnoses: _____

Current Medications (Name, Dosage, Frequency & Date Started): _____

_____

_____

_____

Last Time Medications Taken (if known): Date:_____ Time:_____

Medication Compliance? Yes _____ No _____ Partial _____

Adverse Effects of Medications (i.e. side effects, allergies, poor efficacy): _____

_____

_____

Prior Helpful Medications? Why Discontinued? _____

_____

Is Suicide a Concern? No ___ Yes___ If yes, why? (include prior attempts)

_____

_____

_____

Other medical conditions including allergies, or additional mental health information:

_____

_____

MEDICAL DOCTOR Name: _____ Phone: _____

____ Check here if CONFIDENTIALITY WAIVER BY INMATE accompanies 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