INMATE MEDICATION/MENTAL HEALTH INFORMATION FORM

CORRECTIONAL MEDICAL CARE (HEALTH CARE PROVIDER FOR THE DUTCHESS COUNTY JAIL)
FAX (845) 452-5237 OFFICE PHONE (845) 486-3918 *(CMC is available 24 hours a day, seven days a week)*
Prior to faxing this form you must call the medical department to advise them you will be sending a fax
Faxed to CMC staff (name and title): _____ Hand Delivered to CMC staff (name and title): _____

INMATE INFORMATION

Full Legal Name of Inmate: _____ DOB: _____ Booking #: _____
Street Address: _____ City: _____ State: _____ Zip Code: _____
If no address on file, is the inmate homeless? Yes ____ No ____ If yes, how long? _____

FAMILY CONTACT INFORMATION

Family Contact Name: _____ Relationship to Inmate: _____
Street Address: _____ City: _____ State: _____ Zip Code: _____
Daytime Phone: _____ Evening Phone: _____ Contact Signature: _____

PSYCHIATRIC/MENTAL HEALTH INFORMATION

Does inmate have any history of psychiatric care? Yes ____ No ____
If yes, name of psychiatrist/therapist/last treatment facility: _____Date Last Treated: _____
Has inmate been hospitalized for psychiatric care? Yes ____ No ____
If yes, number of hospitalizations: _____ Date Last Treated: _____
Is suicide a concern? Yes ____ No ____ If yes, why? _____
_____
Has the inmate ever attempted suicide? Yes ____ No ____ If yes, date(s) of attempted suicide and method used:
_____
Is the inmate currently being treated by an inpatient/outpatient facility? Yes ____ No ____
If yes, name of psychiatrist/therapist/last treatment facility: _____ Date Last Treated: _____
Does the inmate have an AOT (Assisted Outpatient Treatment) Order? Yes ____ No ____
Has the inmate had contact with the ACT (Assertive Community Treatment) team? Yes ____ No ____
Psychiatric Diagnosis: _____

MEDICAL INFORMATION

Medical Doctor's Name: _____ Office Phone: _____
Please list all prescribed medications: _____
_____
Name of Pharmacy: _____ Prior Adverse Medication Effects (i.e. side effects, allergies, poor or alarming results): _____
_____
Has the inmate been taking his/her medications? Yes ____ No ____ If no, time span off medication(s)? _____
Please list any medical concerns: _____
_____
Does the inmate self medicate? Yes ____ No ____ If so, with what? _____
Medical Diagnosis: _____
Is the inmate compliant with mental health/medical treatment plan? Yes ____ No ____

Disclaimer: This form is part of a guide entitled "My Family Member/Friend with Mental Illness (Brain Disorder) Has Been Arrested – What Do I Do?" The guide is for educational purposes only and does not constitute legal advice. The NAMI volunteers and others involved in developing the guide and this form are not attorneys. Both are not intended as a substitute for professional legal advice. Please assist your family member/friend with obtaining proper legal representation. Revised 08/2016