THE INMATE MENTAL HEALTH INFORMATION FORM

IMPORTANT INFORMATION

NOTE: DO NOT address any impending charges against your family member in this fax. Medical information only!

- On your FAX cover page, indicate whether your relative has provided you with a written confidentiality waiver. If your relative has not previously done so, ask that he/she be asked to sign one while in jail. The Jail Psychiatric Service staff is prohibited by law from giving anyone information about a client's status unless they have the client's consent, but the staff can receive information from relatives or friends without the client's consent.

- Indicate whether a particular medication has proven to be ineffective or has dangerous and/or uncomfortable side effects.

- Document any history of suicide attempts/threats or other violent intentions in the recent past. Briefly describe the events and when they occurred.

- Indicate any other urgent medical conditions that might require immediate attention, such as diabetes, high blood pressure, seizures, heart problems, etc., and medications currently prescribed for those conditions. Include his/her medical doctor's name, address, and phone number for verification purposes.

- Keep a coy of this fax for future reference.

FAX TO THE NUMBERS BELOW. FAXES CAN BE SENT TWENTY-FOUR (24) HOURS A DAY, SEVEN (7) DAYS A WEEK

Jail Health/Psychiatric Services Fax: (415) 575-4352

Jail Classification Fax: (415) 575-6362

The medical information you provide is tremendously valuable in making an assessment and will help the mental health staff select the best treatment for your relative. There is a clear preference for maintaining effective current treatment. However, the Jail Psychiatric Service staff must conduct its own assessment of your relative's condition and may not necessarily prescribe exactly the same medications.

Inmate Mental Health Information Form

INMATE INFORMATION

FULL LEGAL NAME OF INMATE: _____

STREET ADDRESS: _____CITY: _____ STATE: _____ ZIP CODE: _____

DOB: _____ SSI #:_____

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: _____

MEDICAL INFORMATION

DIAGNOSIS: _____

DAYTIME MEDICATIONS: _____

_____

NIGHTTIME MEDICATIONS: _____

_____

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

_____

IS SUICIDE A CONCERN? NO _____YES _____ IF YES, WHY? _____

_____

_____

_____

OTHER MEDICAL CONCERNS: _____

_____

_____

_____

MEDICAL DOCTOR'S NAME: _____ OFFICE PHONE: _____

STREET ADDRESS: _____CITY: _____ STATE: _____ ZIP CODE:_____

JAIL NOTIFICATION FAX NUMBERS
FAXES CAN BE SENT 24 HOUR A DAY, SEVEN DAYS A WEEK

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