INMATE MENTAL HEALTH INFORMATION FORM

INMATE INFORMATION

FULL LEGAL NAME:______________________________ BIRTHDATE: ______________

ADDRESS BEFORE PRISON:______________________________

CDCR #:__________ HOUSING, IF KNOWN: ______________________________

FAMILY CONTACT INFORMATION

THIS FORM IS BEING COMPLETED BY:______________________________

FAMILY MEMBER WHO CAN BE CONTACTED REGARDING THIS FORM:______________________________

RELATIONSHIP TO INMATE:______________________________

ADDRESS:____________________ CITY:______________ STATE/ ZIP:__________

DAYTIME PHONE:______________ EVENING PHONE:______________ CELL:______________

MENTAL HEALTH INFORMATION

PSYCHIATRIST INFORMATION:

NAME:____________________ ADDRESS:______________________________

PHONE:____________________ APPROXIMATE DATES OF TREATMENT:______________________________

PSYCHOLOGIST/ COUNSELOR INFORMATION:

NAME:____________________ ADDRESS:______________________________

PHONE:____________________ APPROXIMATE DATES OF TREATMENT:______________________________

DESCRIBE THE INMATE'S MENTAL HEALTH HISTORY:______________________________

____

____

DIAGNOSIS:______________________________

MEDICATIONS:______________________________

Side effects or negative reactions to medications:______________________________

ARE YOU WORRIED THAT THE INMATE MIGHT HARM HIMSELF? ☐ NO ☐ YES

If yes, explain your concerns:______________________________

HAS YOUR FAMILY MEMBER ATTEMPTED SUICIDE IN THE PAST? ☐ NO ☐ YES

If yes, provide approximately date(s) and number of suicide attempts/threats:______________________________

What was going on that might have triggered suicidal thoughts or behavior?______________________________

____

____

____

MEDICAL INFORMATION

MEDICAL DOCTOR:

NAME:____________________ ADDRESS:______________________________

PHONE:____________________ APPROXIMATE DATES OF TREATMENT:______________________________

LIST MEDICAL CONCERNS:______________________________

____

MEDICATIONS:______________________________

NORTH KERN STATE PRISON CONTACT INFORMATION

PLEASE FAX OR MAIL THIS FORM TO: DR. GREG HIROKAWA, CHIEF PSYCHOLOGIST

ADDRESS: NORTH KERN STATE PRISON/ P.O. BOX 567/ DELANO, CALIFORNIA 93216-0567 ***or*** **FAX: (661) 721-6262**

NOTE: If you have any additional information you'd like to share, please attach a separate sheet. Thank you for your assistance!

This form was developed with the assistance of NAMI California

FORMULARIO DE INFORMACIÓN DE MEDICACIÓN DE PRESOS

INFORMACIÓN DEL PRESO

NOMBRE LEGAL COMPLETO DEL PRESO:______________________________

CALLE: ______________________CIUDAD: ______________ ESTADO: _____ CÓDIGO POSTAL: ______________

FECHA DE NACIMIENTO ______________ N. DE REGISTRO:______________________

UBICACIÓN EN LA CÁRCEL: TORRE: ____________ PISO: ______________ N. DE PASILLO:______________

INFORMACIÓN DE CONTACTO DE LA FAMILIA

NOMBRE DE FAMILIAR DE CONTACTO: ______________________ RELACIÓN:______________

CALLE: ______________________CIUDAD: ______________ ESTADO: _____ CÓDIGO POSTAL: ______________

N. DE TELÉFONO POR EL DÍA:____________________ N. DE TELÓFONO POR LA NOCHE: ______________

FIRMA DEL CONTACTO x______________________________

INFORMACIÓN DE PSIQUIATRA O CENTRO DE TRATAMIENTO

PSIQUIATRA/ÚLTIMO CENTRO DE TRATAMIENTO: ____________________ULTIMO DÍA DE TRATAMIENTO: ____________

CALLE: ______________________CIUDAD: ______________ ESTADO: _____ CÓDIGO POSTAL: ______________

N. DE TELÉFONO: ______________________ N. DE FAX:______________________

INFORMACIÓN MÉDICA

DIAGNÓSTICO:______________________________

MEDICINAS DE DIA: ______________________________

____

MEDICINAS DE NOCHE: ______________________________

____

EFECTOS NEGATIVOS ANTERIORES (por ejemplo, efectos secundarios, alergias, escasa eficacia): ______________

____

____

¿ES EL SUICIDIO UNA PREOCUPACIÓN? NO ______SÍ ______ EN CASO AFIRMATIVO, ¿POR QUÉ?______________

____

____

____

OTRAS PREOCUPACIONES MÉDICAS:______________________________

____

____

____

NOMBRE DEL MÉDICO: ______________________ N. DE TELEFONO: ______________

CALLE: ______________________CIUDAD: ______________ ESTADO: _____ CÓDIGO POSTAL: ______________

NÚMERO DE FAX DEL SERVICIO DE SALUD MENTAL

NORTH KERN STATE PRISON CONTACT INFORMATION

DR. GREG HIROKAWA, CHIEF PSYCHOLOGIST

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ENVÍE UN FAX A AMBOS NÚMEROS CUANDO OTRAS CONDICIONES MÉDICAS SEAN RELATIVAS