

**STATE OF NEW YORK - DEPARTMENT OF CORRECTIONS AND COMMUNITY SUPERVISION
DOCCS - MENTAL HEALTH REFERRAL**

This form may be completed by any employee to request mental health services for an inmate. **Please press hard - you are making four (4) copies.**

INMATE NAME: _____ DATE: _____

DIN: _____ FACILITY _____ CELL LOCATION: _____ TIME: _____ AM / PM

REFERRED BY: _____ TITLE: _____ EXT.: _____

1. Refer to the checklist below and check each item which applies for the inmate. Please be as complete and accurate as possible.

(COLUMN A) IMMEDIATE PHONE REFERRAL	(COLUMN B) REGULAR REFERRAL
<p><u>KNOWLEDGE OF BASIC FACTS</u> Does not know: <input type="checkbox"/> Own name <input type="checkbox"/> Where he/she is <input type="checkbox"/> Day of week</p> <p><u>POSSIBLE SUICIDE RISK</u> Talks about or writes: <input type="checkbox"/> Feeling hopeless <input type="checkbox"/> Giving up <input type="checkbox"/> Feeling helpless <input type="checkbox"/> Being worthless <input type="checkbox"/> Life not being worthwhile <input type="checkbox"/> Killing self <input type="checkbox"/> Cutting self <input type="checkbox"/> Hanging self <input type="checkbox"/> Overdosing <input type="checkbox"/> Swallowing foreign objects <input type="checkbox"/> Starting fires <input type="checkbox"/> Harming self in other ways</p> <p><u>SELF HARM BEHAVIOR</u> <input type="checkbox"/> Cutting self <input type="checkbox"/> Hanging self <input type="checkbox"/> Overdosing <input type="checkbox"/> Swallowing foreign objects <input type="checkbox"/> Starting fires <input type="checkbox"/> Harming self in other ways <input type="checkbox"/> Banging head</p> <p><u>OTHER</u> <input type="checkbox"/> Please describe reason in comment section</p>	<p><u>NON-VERBAL /UNUSUAL BEHAVIORS</u> <input type="checkbox"/> Repeats same actions with no apparent purpose <input type="checkbox"/> Engages in strange or unusual behavior <input type="checkbox"/> Appears nervous very frequently <input type="checkbox"/> Appears fearful for no apparent reason <input type="checkbox"/> Cries often <input type="checkbox"/> Cries for no apparent reason <input type="checkbox"/> Appears elated very frequently <input type="checkbox"/> Appears sad very frequently <input type="checkbox"/> Laughs for no apparent reason <input type="checkbox"/> Unable to focus attention <input type="checkbox"/> Wears little or no clothing <input type="checkbox"/> Makes strange or unusual movements <input type="checkbox"/> Handles own urine or feces <input type="checkbox"/> Does not speak <input type="checkbox"/> Does not respond to own name <input type="checkbox"/> Refuses to leave cell most of the time <input type="checkbox"/> Refuses to attend program(s) <input type="checkbox"/> Refuses visits <input type="checkbox"/> Has stopped corresponding</p> <p><u>VERBAL BEHAVIORS</u> <input type="checkbox"/> Significant change in communicating <input type="checkbox"/> Does not make sense when speaking <input type="checkbox"/> Yells and screams <input type="checkbox"/> Talks to self</p> <p><u>VERBAL/UNUSUAL THINKING</u> Talks about: <input type="checkbox"/> People being out to get "Me" <input type="checkbox"/> Self in grandiose terms <input type="checkbox"/> Grandiose plans or schemes <input type="checkbox"/> Religious matters in a strange or unusual manner <input type="checkbox"/> Devils or spirits controlling him/her <input type="checkbox"/> Other people being possessed by evil spirits <input type="checkbox"/> Hearing voices</p> <p><u>APPEARANCE AND HYGIENE</u> <input type="checkbox"/> Hair and body appear dirty <input type="checkbox"/> Has offensive odor <input type="checkbox"/> Wears ripped/soiled clothing</p> <p><u>MEDICATIONS</u> <input type="checkbox"/> Refusing medications</p>
	<p><u>EATING AND SLEEPING HABITS</u> <input type="checkbox"/> Significant change in sleeping habits <input type="checkbox"/> Significant decrease in sleep <input type="checkbox"/> Significant increase in sleep <input type="checkbox"/> Significant change in eating habits <input type="checkbox"/> Significant decrease in appetite <input type="checkbox"/> Significant increase in appetite</p> <p><u>SEXUAL ABUSE</u> <input type="checkbox"/> Possible victim of sexual abuse</p> <p><u>SELF REFERRAL</u> <input type="checkbox"/> Inmate requesting to see OMH – note reason in comment section</p> <p><u>OTHER</u> <input type="checkbox"/> Please describe reason in comment section</p>

2. Comments: _____

Actions: •Any box checked in column A, make an immediate phone referral to Mental Health and notify the Watch Commander
•Any box checked in column B, make a regular referral to Mental Health
•If for any other reason you feel there is a problem with the inmate, notify Mental Health and call the Watch Commander.

3. Type of Mental Health Notification: Regular Referral Immediate Phone Referral

If immediate referral, name and title of clinician contacted is required. In addition, at a facility with no Mental Health clinician, print the name of the Watch Commander notified:

NAME & TITLE OF OMH CLINICIAN OR WATCH COMMANDER CONTACTED

TO BE COMPLETED BY MENTAL HEALTH UNIT:

Inmate: _____ was seen on _____ by OMH staff.

COMPLETED BY: _____
Clinician Name Title Phone Extension

The source of a mental health referral and information provided on the referral may be protected from disclosure under Sections 33.13 and 33.16 of the Mental Hygiene Law, if such disclosure could be detrimental to the referral source, the patient, or other persons.

Distribution: Take off Goldenrod copy for the referral source. Provide copy to supervisor: Security send to DSS; Civilian send to DSP

If inmate is placed on a suicide watch in RCTP by DOCCS, this form must be hand delivered to the Mental Health Unit so OMH will have it upon return to duty.

After completion by OMH submit: White - OMH Canary - Referral Source: Security send to DSS; Civilian send to DSP Pink - Medical