

Patient Name:	DIN:	C#:	Unit:
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Transfer to Observation cell: Date: _____ Time: _____	Transferred to Observation cell from: (Circle one): GP, SHU, ICP, TrICP, BHU/TBU/RMHU, 4301, CNYPC/Other	Transfer Initiated by: <input type="checkbox"/> OMH Staff Daytime Hours <input type="checkbox"/> OMH Nurse (Off Hours) <input type="checkbox"/> DOCCS Staff
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Reason for Transfer: Threat of Self-Harm Assaultive Psychiatric Decompensation
 Self-Injurious Behavior Other Mental Health Reason

Type of Observation (Select only one): <u>Started</u>	<u>Ended</u>																														
<table style="width:100%; border-collapse: collapse;"> <tr> <th style="width:15%;"></th> <th style="width:15%;"><u>Date</u></th> <th style="width:15%;"><u>Time</u></th> <th style="width:15%;"></th> <th style="width:15%;"><u>Signature</u></th> </tr> <tr> <td>Suicide Watch</td> <td>_____</td> <td>_____</td> <td>am /pm</td> <td>_____</td> </tr> <tr> <td>Regular 15 Minute Rounds</td> <td>_____</td> <td>_____</td> <td>am /pm</td> <td>_____</td> </tr> </table>		<u>Date</u>	<u>Time</u>		<u>Signature</u>	Suicide Watch	_____	_____	am /pm	_____	Regular 15 Minute Rounds	_____	_____	am /pm	_____	<table style="width:100%; border-collapse: collapse;"> <tr> <th style="width:15%;"></th> <th style="width:15%;"><u>Date</u></th> <th style="width:15%;"><u>Time</u></th> <th style="width:15%;"></th> <th style="width:15%;"><u>Signature</u></th> </tr> <tr> <td>Suicide Watch</td> <td>_____</td> <td>_____</td> <td>am /pm</td> <td>_____</td> </tr> <tr> <td>Regular 15 Minute Rounds</td> <td>_____</td> <td>_____</td> <td>am /pm</td> <td>_____</td> </tr> </table>		<u>Date</u>	<u>Time</u>		<u>Signature</u>	Suicide Watch	_____	_____	am /pm	_____	Regular 15 Minute Rounds	_____	_____	am /pm	_____
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Regular 15 Minute Rounds	_____	_____	am /pm	_____																											

Patient has been provided the following minimum observation cell items listed below unless not approved for clinical/safety reasons.

MINIMUM OBSERVATION CELL ITEMS	Not Approved For Clinical/Safety Reasons		Given			
		Date	Initials		Date	Initials
One (1) specialized tear resistant smock	<input type="checkbox"/>			<input type="checkbox"/>		
Two (2) specialized tear resistant safety mats	<input type="checkbox"/>			<input type="checkbox"/>		
Specialized tear/fire resistant mattress	<input type="checkbox"/>			<input type="checkbox"/>		
Paper Slippers	<input type="checkbox"/>			<input type="checkbox"/>		
Soap <i>(Return following use)</i>	<input type="checkbox"/>			<input type="checkbox"/>		
Toothbrush <i>(Return following use)</i>	<input type="checkbox"/>			<input type="checkbox"/>		
Toothpaste <i>(Return following use)</i>	<input type="checkbox"/>			<input type="checkbox"/>		
Eating Utensil <i>(Return following use)</i>	<input type="checkbox"/>			<input type="checkbox"/>		
Shower per DOCCS Schedule	<input type="checkbox"/>			<input type="checkbox"/>		
Feminine Hygiene items <i>(If needed)</i>	<input type="checkbox"/>			<input type="checkbox"/>		
ECOSECURITY UTENSIL <i>(Given In lieu of Eating Utensil; Requires approval of Unit Chief and/or UC and DSS)</i>	<input type="checkbox"/>			<input type="checkbox"/>		
OBSERVATION WRAP <i>(Given In lieu of Smock; Requires approval of Unit Chief and/or UC and DSS)</i>	<input type="checkbox"/>			<input type="checkbox"/>		

Based on clinical determination, indicate those additional amenities provided with dates and initials.

ADDITIONAL OBSERVATION CELL ITEMS	Given		Not Approved For Clinical/Safety Reasons		Given				
		Date	Initials		Date	Initials		Date	Initials
Extra specialized tear resistant safety mat	<input type="checkbox"/>			<input type="checkbox"/>			<input type="checkbox"/>		
Mail/Reading Material <i>(Without Staples)</i>	<input type="checkbox"/>			<input type="checkbox"/>			<input type="checkbox"/>		
Pen <i>(Bendable)</i>	<input type="checkbox"/>			<input type="checkbox"/>			<input type="checkbox"/>		
Writing Paper	<input type="checkbox"/>			<input type="checkbox"/>			<input type="checkbox"/>		
Pajamas	<input type="checkbox"/>			<input type="checkbox"/>			<input type="checkbox"/>		
Underwear	<input type="checkbox"/>			<input type="checkbox"/>			<input type="checkbox"/>		
Shirt/Pants <i>(State Greens)</i>	<input type="checkbox"/>			<input type="checkbox"/>			<input type="checkbox"/>		
Socks	<input type="checkbox"/>			<input type="checkbox"/>			<input type="checkbox"/>		
Blanket	<input type="checkbox"/>			<input type="checkbox"/>			<input type="checkbox"/>		
Other: <i>(Specify)</i>	<input type="checkbox"/>			<input type="checkbox"/>			<input type="checkbox"/>		

Transferred Out of RCTP Observation Cell: Date: _____ Time: _____	Signature: _____ Title: _____ Psychiatrist/NP or Unit Chief/Designee
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