IDAHO DEPARTMENT OF CORRECTION
Mental Health Screening

Resident Name: IDOC #:	DOB:	Date of Report:

☐ Intake/New Arrival ☐ Inter Institutional Transfer ☐ Restrictive Housing

Current Risk Factors	1. Did the transporting officer report any concerns? If so please explain:	☐Yes	☐No	**Immediately notify the shift commander**
	2. Right now, do you have thoughts of hurting yourself?	☐Yes	☐No	
	3. Do you have any <u>immediate</u> plans to hurt yourself? Describe:	☐Yes	☐No	
	4. Right now, are you currently feeling hopeless about your future?	☐Yes	☐No	**Refer to MH for follow up within 24 hrs**
	5. Right now, do you have any mental health symptoms or complaints? On a 1-10 scale with 1 being *none at all* and 10 being *extremely serious*; rate your symptoms. Describe symptoms: **(If rated at "5" or above, refer for clinician follow-up)**	☐Yes	☐No	
	6. Within the past year have you engaged in self-harm or attempted suicide? Date: _____Means/Method:_____Intent:_____	☐Yes	☐No	
Prior Emergent Treatment	7. Within the last 24 months, have you had a mental health hospitalization or been placed on a mental health observation/watch in a correctional facility ? Date: _____ Hospital/Facility: _____ Reason: _____ Date: _____ Hospital/Facility: _____ Reason: _____	☐Yes	☐No	**Refer to MH for follow up within 72 hours**
Suicide/ Self Harm History	8. Within the last 24 months, have you engaged in self-harm or attempted suicide? Date: _____Means/Method: _____Intent:_____ Date: _____Means/Method: _____Intent:_____	In custody: ☐Yes ☐Yes	☐No ☐No	
Medication	9. Are you currently taking mental health medications? Name: _____Dose/Freq:_____Last dose: _____Pharm: _____Prescriber:_____ Name: _____Dose/Freq:_____Last dose: _____Pharm: _____Prescriber:_____ Name: _____Dose/Freq:_____Last dose: _____Pharm: _____Prescriber:_____	☐Yes	☐No	**Follow up to occur within 14 days if indicated following clinician review.**
	10. Have you ever taken mental health medications in the past? Name: _____Dose/Freq:_____Last dose: _____Pharm: _____Prescriber:_____ Name: _____Dose/Freq:_____Last dose: _____Pharm: _____Prescriber:_____ Name: _____Dose/Freq:_____Last dose: _____Pharm: _____Prescriber:_____	☐Yes	☐No	
Mental Health Treatment	11. Prior to 24 months ago, have you been hospitalized for mental health reasons? Date: _____ Hospital/Facility: _____Reason: _____ Date: _____ Hospital/Facility: _____Reason: _____	☐Yes	☐No	
	12. Prior to 24 months ago, have you attempted suicide or engaged in self-harm? Date: _____Means/Method: _____Intent:_____ Date: _____Means/Method: _____Intent:_____	In custody: ☐Yes ☐Yes	☐No ☐No	
	13. Do you have a history of outpatient mental health treatment? Date: _____ Care Provider: _____Reason: _____ Date: _____ Care Provider: _____Reason: _____	☐Yes	☐No	

Substance Use

14. Have you ever used any type of substances: ☐Yes ☐No

What? First Used: Last Used: How Much?	What? First Used: Last Used: How Much?
☐Alcohol:	☐Marijuana:
☐Methamphetamines:	☐Cocaine:
☐Prescription drugs:	☐Heroin:
☐Other:	

Other contributing suicide risk factors

15. Is this your first time in prison?	☐Yes	☐No
16. Have any family members or significant persons in your life attempted or committed suicide?	☐Yes	☐No
17. Have you recently experienced a significant loss such as a death of a close family member or friend?	☐Yes	☐No
18. Have you ever been arrested for a sex crime?	☐Yes	☐No
19. Have you ever been a victim of sexual or physical abuse?	☐Yes	☐No
20. Have you had a head injury? Describe:	☐Yes	☐No
21. Have you ever received special education services?	☐Yes	☐No
22. Are you worried about something other than your current legal situation? Describe:	☐Yes	☐No
23. Do you have a physical illness that is causing you distress or pain? Describe:	☐Yes	☐No

Mental Health Screening

Current Mental Health Status (Check all that apply)

☐ Alert, oriented x _____ ☐ Disoriented ☐ Reports Hallucinations ☐ Endorses Delusions

Grooming/ Hygiene	Eye Contact	Affect	Mood	Thought Process	Speech	Movement/Activity
☐ Appropriate to situation ☐ Neat/Clean ☐ Unkempt ☐ Dirty ☐ Other:	☐ Appropriate to situation ☐ Fair ☐ Good ☐ None	☐ Appropriate to situation ☐ Flat ☐ No emotion ☐ Tearful ☐ Smiling ☐ Depressed ☐ Euphoric	☐ Appropriate to situation ☐ Angry ☐ Cheerful ☐ Calm ☐ Sad ☐ Hopeless ☐ Anxious	☐ Appropriate to situation ☐ Logical ☐ Goal directed ☐ Disorganized ☐ Moving from topic to topic quickly ☐ Irrelevant ☐ Distractible	☐ Appropriate to situation ☐ Rapid ☐ Slow ☐ Pressured ☐ Slurred ☐ Loud ☐ Quiet ☐ Rambling	☐ Appropriate to situation ☐ Restless ☐ Slowed ☐ Active ☐ Agitated ☐ Aggressive

DISPOSITION

Action Taken	Initial Housing Recommendation
☐ **Emergent/Urgent:** Referred to the Shift Commander under Policy 315 ☐ Refer to Mental Health for follow up within 24 hours ☐ Refer to Mental Health for follow up within 72 hours ☐ Refer to Mental Health for follow up within 14 days if indicated following clinician review ☐ No need for Mental Health follow up - cleared	☐ Cleared for general housing placement ☐ Not cleared - referred for holding cell placement ☐ Other placement: _____ _____

Informed Consent

I acknowledge that I have answered all questions truthfully and have been informed about how to obtain mental health services. I consent to routine mental health care provided by facility healthcare professionals.

Resident Signature:_____Date: _____

Screener/ Reviewer

Screened by: _____ _____ _____ _____
Date Time Printed Name/Title Signature

Screening Reviewed: _____ _____ _____ _____
Date Time Printed Name/Title Clinician Signature

☐ MH Secondary Assessment Completed: _____ _____ _____
Date Printed Name/Title Signature

Clinical Follow Up

Follow Up SOAP Note/if indicated:

_____ _____ _____ _____
Date Time Printed Name/Title Clinician Signature