GEORGIA DEPARTMENT OF CORRECTIONS

Specialized Mental Health Treatment Unit Recommendation Form

Date: ________ Offender Name: ______________________

GDC #: ______________________________

DOB: _______________ Race: __________

Referring facility ______________________________

Consideration should be given for placement in the following unit:

[ ] Serious Mental Illness (specify type): ___________________________________
[ ] Severe Personality Disorder (specify type):
[ ] Dementia / Traumatic Brain Injury (circle type and identify the cause): _______________________
[ ] Severe Impulse Control Disorder (specify primary impulse): ______________________________
[ ] Developmental Delays/Deficits (specify primary deficit(s)):
[ ] Severely Dangerous Mentally Ill: (indicate date of most recent assault): _____________________
[ ] Completed other Specialized Unit-in need of Transitional Programming

Justification for placement (This area must be completed. Attach additional information):

Signatures:

Offender – GDC#	**Printed name**
Warden/Designee	**Printed Name**
Deputy Warden, Care & Treatment	**Printed Name**
Security Representative /Multifunctional C.O.	**Printed Name**
Mental Health Unit Manager	**Printed Name**
Clinical Director/Psychologist	**Printed Name**
Mental Health Counselor	**Printed Name**
Activity Therapist	**Printed Name**

Retention Schedule: Upon completion, this form shall be placed in the offender's mental health file (section 8). At the end of the offender's need for mental health services and/or sentence, the mental health file shall be placed within the offender's health record and retained for ten (10) years.