Georgia Department of Corrections Name: __________________ GDC #: ________________

Mental Health Reception Screen Form DOB: ____________ Race: ________ Sex: __________

Facility:_____________________ Date:_________________

Questions	Yes	No	If yes, please explain
1. Are you currently prescribed psychotropic medications or have been prescribed within last 6 months medications for a mental illness?			If yes, name of medication(s):
2. Do you have a history of self-injury or a suicide attempt?			If so, when?
3. Have you had a serious suicide attempt/plan in the past year?			
4. Do you have present thoughts or plans of self-injury or suicide?			
5. Do you have a mental health inpatient history? [do not include substance abuse treatment—see #14]			If so, when? [Refer for MH evaluation if inpatient treatment occurred<5 years ago]
6. Do you have a mental health outpatient history? [do not include substance abuse treatment—see #14]			If so, when? [Refer for MH evaluation if outpatient treatment occurred <5 years ago]
7. Did you have mental health treatment in jail/prison?			
8. Do you have a history of being a victim of abuse? (physical / psychological / sexual)			If yes, is mental health treatment desired? Circle: yes no
9. Do you identify as transgender or intersex?			If yes/no, are there observable physical characteristics of the opposite gender? Circle: yes no
10. Have you ever hurt another person sexually? Have you ever been charged with a sex offense?			If yes, is treatment desired? Circle: yes no (If yes, person completing this form must contact DW of Care & Treatment for a Risk Reduction Services referral)
11. Do you have a history or current thoughts of assaultive/violent behavior?			
12. Do you have a history of head trauma?			
13. Do you have a history of special education/disability benefits?			
14. Do you have a history of substance abuse treatment?			If so, when? Type: [ ] Inpatient [ ] Outpatient

FOR INTRA-SYSTEM TRANSFERS to non-mental health facilities. This is only a screen, not meant for referrals unless, offender answers yes to questions 1 – 8. If so, contact the catchment area facility to schedule a follow-up with a Mental Health Provider within 14 calendar days. For questions 9-14 contact the catchment area facility for guidance.

Are there risk factors associated with the offender's situation that suggest the need for further evaluation/monitoring (e.g., high profile case with offense that puts offender at risk with peers; lengthy sentence, particularly if first incarceration)? [ ] Yes [ ] No

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Clinical Impressions and behavioral observations: ____

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[ ] Further Mental Health Evaluation (may need services) **[ ] No Further Mental Health Evaluation**

_______________________________ _______________________________

Signature (staff member completing this form)/Title Print Name

_______________________________ _______________________________

Reviewer's Signature (Catchment area Clinical Director/Consultant)/Title Print Name

Form no. M30-01-01

Retention Schedule: Upon completion, this form shall be placed in the offender's medical file (original - section 5) and mental health file (copy-section 4). 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 10 years.