Georgia Department of Corrections	**Institution: _____**
Mental Health Services	**Name: _____**
Comprehensive Treatment Plan Review	**GDC ID#: _____**
	DOB: _____
Date: _____	**Race: _____ Sex: _____**

Principal Diagnosis: _____

Other Diagnoses: _____

_____

_____

General medical condition(s) relevant to mental disorder: _____

Utilization Review:

- **Current Level of Care: [ ] Level 2 [ ] Level 3 [ ] Level 4**
- **Recommended Level of Care: [ ] Level 1 [ ] Level 2 [ ] Level 3 [ ] Level 4**
- **Justification: _____**

_____

_____

Summary of Progress and Changes in Goals, Interventions and Level of Care justification:

Due Date of Next Review: _____

_____ _____ _____ _____

Offender Signature **GDC ID#** **Date** **Printed/Typed Name**

_____ _____ _____

Primary Service Provider Signature **Date** **Printed/Typed Name**

_____ _____ _____

Psychologist Signature **Date** **Printed/Typed Name**

_____ _____ _____

Psychiatrist / APRN Signature **Date** **Printed/Typed Name**

Retention Schedule: Upon completion, this form shall be placed in the offender's mental health file (section 2). 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.