THE INMATE MENTAL HEALTH INFORMATION FORM

IMPORTANT INFORMATION

NOTE: DO NOT address any impending charges against your family member in this fax. Medical information only!

- On your FAX cover page, indicate whether your relative has provided you with a
 written confidentiality waiver. If your relative has not previously done so, ask
 that he/she be asked to sign one while in jail. The Jail Psychiatric Service staff is
 prohibited by law from giving anyone information about a client's status unless
 they have the client's consent, but the staff can receive information from relatives
 or friends without the client's consent.
- Indicate whether a particular medication has proven to be ineffective or has dangerous and/or uncomfortable side effects.
- Document any history of suicide attempts/threats or other violent intentions in the recent past. Briefly describe the events and when they occurred.
- Indicate any other urgent medical conditions that might require immediate attention, such as diabetes, high blood pressure, seizures, heart problems, etc., and medications currently prescribed for those conditions. Include his/her medical doctor's name, address, and phone number for verification purposes.
- Keep a coy of this fax for future reference.

FAX TO THE NUMBERS BELOW. FAXES CAN BE SENT TWENTY-FOUR (24) HOURS A DAY, SEVEN (7) DAYS A WEEK

Jail Health/Psychiatric Services Fax: (415) 575-4352

Jail Classification Fax: (415) 575-6362

The medical information you provide is tremendously valuable in making an assessment and will help the mental health staff select the best treatment for your relative. There is a clear preference for maintaining effective current treatment. However, the Jail Psychiatric Service staff must conduct its own assessment of your relative's condition and may not necessarily prescribe exactly the same medications.

Inmate Mental Health Information Form INMATE INFORMATION

FULL LEGAL NAME OF INMATE:		
STREET ADDRESS:	CITY:	STATE: ZIP CODE:
DOB: SSI #:		
FAMI	LY CONTACT INFOR	RMATION
		RELATIONSHIP:
STREET ADDRESS:	CITY:	STATE: ZIP CODE:
DAYTIME PHONE:	EVENING PH	HONE:
CONTACT SIGNATURE: x		
<u>PSYCHIATRIST</u>	TREATMENT FACIL	<u>ITY INFORMATION</u>
PSYCHIATRIST/LAST TREATMENT FACILITY:		DATE LAST TREATED:
STREET ADDRESS:	CITY:	STATE: ZIP CODE:
PHONE:	FAX:	
<u> </u>	MEDICAL INFORMAT	<u>rion</u>
DIAGNOSIS:		
DAYTIME MEDICATIONS:		
NIGHTTIME MEDICATIONS:		
PRIOR ADVERSE MEDICATION EFFECTS (i.e. side effect	s, allergies, poor efficacy):	
IS SUICIDE A CONCERN? NOYES IF YES	S, WHY?	
OTHER MEDICAL CONCERNS:		
MEDICAL DOCTOR'S NAME:		OFFICE PHONE:
STREET ADDRESS:	CITY	STATE: ZIP CODE:

JAIL NOTIFICATION FAX NUMBERS FAXES CAN BE SENT 24 HOUR A DAY, SEVEN DAYS A WEEK

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