Georgia Department of Corrections
Initial Psychiatric/Psychological Evaluation
(circle)

Date: ___________________________

Facility: ___________________________________
Name: ___________________________________
GDC #: ___________________________________
DOB: ___________________________________
Race: _______________ Sex: ________________

Location: [ ] Private Office [ ] Cell Front
[ ] On-site [ ] Remote (tele-psychiatry/psychology)

Referral Information (including referral source and current medications) and Chief Complaint:

____

____

Summary of Relevant MH History (include history of signs/symptoms since childhood, treatment, medications, etc.):

____

____

____

____

____

____

____

Substance Use History: ____

____

____

Substance Use Interventions [ ] No [ ] Yes Specify:__________________________________

Trauma Abuse History: [ ] Yes [ ] No [ ] Sexual [ ] Physical [ ] Psychological
[ ] Not Clinically Relevant [ ] Clinically Relevant

____

____

Biological Family Mental Health History: ____

____

Violence History:
Toward Others [ ] Yes [ ] No Toward Animals [ ] Yes [ ] No
Gang Involvement: [ ] Yes [ ] No Fire Setting: [ ] Yes [ ] No
Use of Weapons [ ] Yes [ ] No Other: ___________________________________

Retention Schedule: Completed forms shall be placed in the offender’s mental health file (section 4) and a copy placed in the medical file (section 5). 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.

Name: ______________________________ **GDC#:** ______________________ **Date:** _________

Medical History: ____

____

Self-Injury History/Risk Factors: ____

____

____

Mental Status Exam:

____

____

____

____

____

____

Clinical issues related to gender/transgender identification: _______________________________

____

Additional justification for diagnosis: ____

____

<u>Principal Diagnosis</u>: ____

Other Diagnoses in order of focus of attention and treatment: _________________________________

____

____

If added to the caseload, Mental Health Diagnosis List and Medical Problem List completed: [ ] Yes

Plan: ____

____

Recommended Mental Health Level: [ ] I [ ] II [ ] III [ ] IV

Refer to MD/APRN [ ] Yes [ ] No [ ] N/A

Psychologist/Psychiatrist (circle): ____

_____________________________________ _________________________________ ___________
Signature Print Last Name Date

Retention Schedule: Completed forms shall be placed in the offender's mental health file (section 4) and a copy placed in the medical file (section 5). 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.

Name: ______________________________ GDC#: _____________________ Date: ________

****

To be completed by psychiatrist/CNS if Needed - (for additional history, use & attach supplementary form)

Medical Allergy:

____

Relevant Medical Conditions (to include intersex status):

____

____

____

Additional History:

____

____

____

____

____

[ ] I acknowledge diagnoses on page two with these considerations:

____

____

____

Other Plans: ____

____

____

Medication Consent [ ] Yes [ ] N/A ° **Labs** [ ] Yes [ ] N/A ° **AIMS** [ ] Yes [ ] NA

Return to Clinic: ___________________________

____ ___________________________ ___________

Psychiatrist Signature Print Last Name Date

[ ] There are no additional pages of the initial evaluation ---OR ---
[ ] There are additional pages attached.

Retention Schedule: Completed forms shall be placed in the offender's mental health file (section 4) and a copy placed in the medical file (section 5). 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.