



KAY IVEY
GOVERNOR

State of Alabama Department of Corrections

Alabama Criminal Justice Center
301 South Ripley Street
P. O. Box 301501
Montgomery, AL 36130-1501
(334) 353-3883



JOHN Q. HAMM
COMMISSIONER

March 8, 2024

ADMINISTRATIVE REGULATION
NUMBER 604

OPR: HEALTH SERVICES

CONFIDENTIALITY IN MENTAL HEALTH SERVICES

I. GENERAL

This Alabama Department of Corrections (ADOC) Administrative Regulation (AR) establishes the policies, procedures, and responsibilities regarding the expectations and limits of confidentiality when mental health services are provided to inmates within ADOC custody.

II. POLICY

It is the policy of the ADOC to ensure that inmates within ADOC custody are provided information on the nature and applicable limits on confidentiality before initiating mental health services.

III. DEFINITION(S) AND ACRONYM(S)

- A. **Confidentiality**: Provision or documentation of services in a manner such that Protected Health Information cannot be overheard or otherwise accessed by unauthorized persons.
- B. **Health Insurance Portability and Accountability Act (HIPAA)**: the federal law that establishes national standards to protect individual's health records and identifiable protected health information.
- C. **Informed Consent**: The process of informing an inmate of the risks and benefits of a proposed treatment, as well as alternative treatment options, and documenting in writing the inmate's decision to accept (or reject) the recommendation.
- D. **Mental Health Caseload**: The database that identifies all inmates within ADOC custody who are in need of mental health services.

- E. **Protected Health Information (PHI)**: Under the HIPAA Privacy Rule, PHI refers to individually identifiable health information that is held or transmitted in any form, such as medical records, incident reports, electronic records, and any other form or medium. Such information includes any past, current, or future physical or mental health conditions of the individual, the fact of providing care to the individual, or the fact of payment for health care.
- F. **Qualified Mental Health Professional (QMHP)**: A psychiatrist, psychologist, licensed professional counselor, mental health nurse practitioner, mental health social worker, mental health nurse, or other clinician who, by virtue of their education, credentials, and experiences, are permitted by law to evaluate and care for the mental health needs of patients.

IV. **RESPONSIBILITIES**

- A. The ADOC Director of Mental Health Services is responsible for ensuring oversight of the development of this AR.
- B. The ADOC Director of Psychiatry is responsible for ensuring this AR is consistent with relevant professional standards.
- C. ADOC Regional Psychologists are responsible for oversight and monitoring of the implementation of this AR.
- D. The Warden (or designee) at each facility is responsible for ensuring that all ADOC staff at that facility receive training on the implementation of this AR.
- E. The Vendor Mental Health Program Director is responsible for ensuring that all Vendor staff receive training on the implementation of this AR.
- F. The Vendor Mental Health Site Administrator and the Vendor Health Services Administrator at each facility are jointly responsible for ensuring that all Vendor staff at that facility receive training on the implementation of this AR.
- G. The ADOC General Counsel will be responsible for ensuring this AR complies with all laws, including, but not limited to HIPAA.

V. **PROCEDURES**

- A. Informed Consent:
 - 1. The Vendor mental health staff will obtain Informed Consent from an inmate before beginning mental health services:
 - a. The Vendor mental health staff will obtain verbal Informed Consent from an inmate who wishes, but is unable or unwilling, to provide written Informed Consent to mental health services.

- b. The Vendor mental health staff obtaining verbal Informed Consent from an inmate will request two (2) additional Vendor mental health staff to witness that inmate providing verbal Informed Consent.
 - c. The two (2) Vendor mental health staff witnessing an inmate's verbal informed consent will sign the appropriate Informed Consent for as witnesses in place of that inmate.
 2. The Vendor mental health staff may provide the following mental health services to an inmate in emergency circumstances regardless of whether that inmate provides Informed Consent:
 - a. Emergency psychotropic medication in accordance with AR 620, *Emergency Administration of Psychotropic Medication*.
 - b. Involuntary medication status in accordance with AR 621, *Administrative Review of Involuntary Psychotropic Medication*.
 - c. Emergency mental health services in accordance with AR 627, *Mental Health Crisis Intervention and Emergency Services*.
 - d. Temporary use of clinical restraints in accordance with AR 631, *Use of Clinical Restraints for Mental Health Purposes*.
 3. The Vendor mental health staff providing mental health services to an inmate in emergency circumstances will document the need and administration of the emergency mental health services on the appropriate progress note (i.e., ADOC Form MH-025, *Psychiatrist/CRNP Progress Note*, ADOC Form MH-040, *Progress Note*, or ADOC Form MH-040N, *Nursing Progress Note*).
 4. The Vendor mental health staff will employ interventions to encourage mental health services for an inmate who refuses those services.
 5. The Vendor mental health staff will consider referring an inmate who continuously refuses mental health services to a higher level of care that is necessary to permit that inmate's safe and effective functioning.

B. Confidentiality and its Limitations:

1. The Vendor staff have a duty to obtain informed consent, which includes providing information on the nature and applicable limits on confidentiality, from each inmate on, or being considered for addition to, the Mental Health Caseload before initiating mental health services.
2. The Vendor staff will document and review an inmate's understanding, of informed consent on one of the appropriate following forms:

- a. ADOC Form MH-018, *Psychiatric Evaluation*.
 - b. ADOC Form MH-025, *Psychiatrist/CRNP Progress Note*.
 - c. ADOC Form MH-040, *Progress Note*.
3. Confidentiality applies to all aspects of PHI, including individual counseling sessions, medication-management encounters, periodic mental-health assessments, suicide-risk assessments, therapeutic group sessions, etc.
 4. The Vendor staff will take reasonable steps to ensure all mental health services are provided in a confidential out-of-cell setting.
 5. The Vendor staff will document the setting in which the mental health services are provided and whether such setting provided confidentiality on one of the appropriate following forms:
 - a. ADOC Form MH-018, *Psychiatric Evaluation*.
 - b. ADOC Form MH-025, *Psychiatrist/CRNP Progress Note*.
 - c. ADOC Form MH-040, *Progress Note*.
 4. The Vendor staff may limit confidentiality when:
 - a. Members of an inmate's Treatment Team share PHI in the context of treatment planning.
 - b. An inmate reports thoughts, plans, or intentions to self-harm or harm another person.
 - c. An inmate engages in behavior that presents a risk to the safety and security of the facility and staff.
 - d. The Vendor staff becomes aware that an inmate presents a risk of escape.
 - e. A legal duty requires Vendor staff to report suspicions or evidence of the abuse or neglect of a child, elder, or disabled person to appropriate authorities.
 - f. An inmate must be transferred to a specialized mental health unit, crisis cell, or outside health care facility.
 - g. Other specific needs require specific disclosures (e.g., new mental health program assignment, medical reasons, security reasons, etc.).

5. The Vendor staff may provide mental health services in a non-confidential setting if a confidential out-of-cell setting is either not possible due to safety concerns or is otherwise not appropriate.
 - a. The Vendor staff will use clinical judgment when determining whether a confidential out-of-cell setting “is otherwise not appropriate.”
 - b. If a confidential out-of-cell setting is not appropriate, then Vendor staff shall document the fact, the reason for it, and any actions taken to maximize confidentiality on one of the appropriate following forms:
 - (1) ADOC Form MH-018, *Psychiatric Evaluation*.
 - (2) ADOC Form MH-025, *Psychiatrist/CRNP Progress Note*.
 - (3) ADOC Form MH-040, *Progress Note*.
6. When mental health services are provided in a non-confidential setting in accordance with Section V.B.4., Vendor staff will share limited mental health information with ADOC security staff and ADOC classification staff that is specifically relevant to aiding in the protection of an inmate or maintaining safety and security of others and the facility.
7. The following individuals may also request to have access to mental health records on a “need-to-know” basis:
 - a. ADOC Law Enforcement Services Division (LES D).
 - b. ADOC Legal Division or other legal representation.
 - c. ADOC Office of Health Services (OHS) Division.
 - d. The Warden (or designee) at the facility where an inmate is housed when necessary for the safety of an inmate or operation of the facility.
 - e. ADOC security staff who are members of an inmate’s Treatment Team, provided that such information shall not be discussed with or disseminated to any person other than Vendor staff providing care to the inmate.
 - f. Other individuals specifically authorized by valid court order or judgment.
8. The Vendor shall investigate potential breaches of confidentiality, and verified breaches of confidentiality may result in corrective action.

C. Training:

1. All ADOC staff and Vendor staff will complete all required and applicable trainings, which includes a unit on confidentiality, in accordance with AR 608, *Staff Training in Mental Health*.
2. All ADOC security staff will complete all required and applicable trainings, which include a unit on confidentiality, in accordance with AR 219, *Training*.

D. Orientation for Inmates at Reception and Following Transfer:

The Vendor staff will provide an inmate with information on the nature and limitations of confidentiality during inmate orientation at both Reception Mental Health Screening and intra-system transfer to another ADOC facility in accordance with AR 611, *Inmate Orientation to Mental Health Services*.

E. Release of PHI.

1. The Vendor staff may only release an inmate's PHI to another mental health care facility outside ADOC if that inmate has provided signed consent on ADOC Form MH-001, *Inmate Authorization for Release of Health Records*.
2. Upon receipt of a request for release of an inmate's PHI, only the Vendor staff is permitted to copy and provide documentation from that inmate's medical record in accordance with federal and state law.
3. The Vendor staff will:
 - a. File the original ADOC Form MH-001, *Inmate Authorization for Release of Health Records*, in the inmate's medical record,
 - b. Include a copy of ADOC Form MH-001, *Inmate Authorization for Release of Health Records*, with any information shared with another mental health care facility outside ADOC.

VI. DISPOSITION

Any forms used will be disposed of and retained according to the Departmental Records Disposition Authority (RDA).

VII. FORMS

- A. ADOC Form MH-001, *Inmate Authorization for Release of Health Records*.
- B. ADOC Form MH-002, *Inmate Orientation to Mental Health Services*.

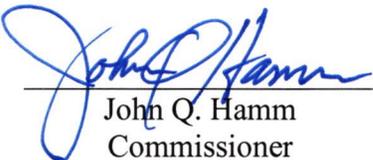
- C. ADOC Form MH-018, *Psychiatric Evaluation*.
- D. ADOC Form MH-025, *Psychiatrist/CRNP Progress Note*.
- E. ADOC Form MH-040, *Progress Note*.
- E. ADOC Form MH-040N, *Nursing Progress Note*.

VIII. SUPERSEDES

This Administrative Regulation supersedes AR 604, *Confidentiality in Mental Health Services and Mental Health Documentation*, dated May 11, 2005, and any related changes.

IX. PERFORMANCE

- A. Code of Alabama 1975 § 14-1-1.1 *et seq.*
- B. *Braggs v. Hamm*, No. 2:14-cv-00601-MHT-JTA (M.D. Ala. filed June 17, 2014).
- C. NATIONAL COMMISSION ON CORRECTIONAL HEALTH CARE, STANDARDS FOR MENTAL HEALTH SERVICES IN CORRECTIONAL FACILITIES (2015).
- D. NATIONAL COMMISSION ON CORRECTIONAL HEALTH CARE, STANDARDS FOR HEALTH CARE SERVICES IN PRISONS (2018).



John Q. Hamm
Commissioner

Alabama Department of Corrections
**Inmate Authorization for Release of Health
Records**



Inmate Name:	AIS Number:	Date of Birth:
Institution Releasing Information:	Date:	ADOC Contractor:

I am either the patient named above or the patient's legally authorized representative.
By signing this form, I authorize and release the Alabama Department of Corrections, the ADOC health contractor(s), and the institution from liability relating to the release of the following information, including protected health information, included in my health record to:

Name / Agency:	Address:	City, State, Zip Code:
Information to be released: (Please select all records needed)	From Date:	To:
Admission Reports	Discharge Reports	X-Ray Reports
Operative Summary Reports	Special Studies Reports	Laboratory Reports
Immunization History	Mental Health Reports*	Psychiatric Summary Reports*
Drug/Alcohol History and Counseling*	HIV Status and Treatment*	Sexually Transmitted Diseases Status and Treatment*
Other (specify):		

Purpose for which disclosure is being made:			
Doctor	Insurance	Attorney	
Other (specify):			

*I understand that my expressed consent is required to release any health information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, and/or drug and/or alcohol use.
You are hereby specifically authorized to release all health care information relating to such testing, diagnosis, and/or treatment of the aforementioned conditions.

Signature of Patient or Authorized Representative	Date
I understand health records cannot be disclosed without written consent, except as provided for under federal or state law. This authorization is valid for one year after the date signed and is subject to revocation by me at any time if provided in writing to ADOC, the health contractor(s), or the institution, except to the extent that disclosure has already been disclosed in reliance on this authorization. State law provides that a reasonable fee may be charged for the production of these records.	

Signature of Patient or Authorized Representative	Date
*Authorized Representative's relationship to patient and authority to act for patient:	

Alabama Department of Corrections
INMATE ORIENTATION TO MENTAL HEALTH SERVICES



The Alabama Department of Corrections provides comprehensive mental health services including, but not limited to:

- Assessment and treatment of mental health problems and disorders.
- Referral to a psychiatrist when indicated for diagnostic evaluation and medication management when recommended as part of a comprehensive treatment plan.
- Group and individual counseling.
- Crisis intervention and management.
- Residential mental health treatment and hospitalization, if necessary.

Adjusting to incarceration and it is not unusual for a person to experience distress, including a sense of grief and loss. More information is available to answer any questions you may have about coping with stress, mental illness, and treatment for substance use disorders. In addition, mental health staff are trained and available to talk with you about special needs such as gender-related issues, eating disorders, or other topics related to your wellbeing.

If you wish to schedule an appointment with mental health staff to address your concerns, please complete a Mental Health Referral Form (MH-008). Place the completed Referral form in the Mental Health Referral box or the Sick Call box. NOTE: If you are experiencing a mental health emergency, or if you have concerns that need to be addressed immediately, notify any ADOC staff, medical or mental health staff member.

Your participation in mental health services is voluntary, except in emergency situations where there is an immediate risk to your safety, that of others, or the operation of the facility. In addition, under limited circumstances, individuals experiencing a serious mental illness that creates a clear risk to themselves or others may be provided due process through the administrative review process that determines if they are required to receive treatment.

Mental health and medical staff work together to address your needs, and both have access to all of your health records. Ordinarily, information about the mental health services you receive is confidential. However, in some circumstances, mental health staff are legally or ethically required to share treatment information to ensure your well-being or the well-being of others. In the interest of keeping, you and others safe, mental health staff are required to disclose information about your mental health treatment to others if you:

- Report that you have thoughts, plans, or intentions to harm yourself or others.
- Present a danger of injury to yourself or others.
- Require movement to a new program assignment, special unit or cell for observation and mental health treatment.
- Require transfer to a psychiatric hospital outside of the prison.
- Present a reasonably clear risk of escape or creation of institutional disorder.

Mental health staff members also have a legal duty to report to appropriate authorities any unreported, suspected abuse or neglect of a child.

To address any of the required disclosures mentioned above, your mental health records may be shared on a need-to-know basis with the Warden or designee, internal investigative staff, ADOC legal counsel, departmental and accrediting audit staff; and persons authorized by court order or judgment. These individuals will take all necessary steps to ensure the privacy of your information is maintained. All other persons or agencies require an authorization for release of information signed by you before they can access your mental health records.

Finally, while ADOC strives to meet the needs of each individual's mental health needs, if you believe the mental health services provided to you are inadequate and you are not able to address your concerns through discussion with clinical staff you may file an inmate grievance (Health Services Inmate Grievance Form).

My signature below signifies that the information on this form has been explained to me and I have received a copy of this information for my future reference.

Inmate Signature

AIS#

____/____/____
Date

Alabama Department of Correction
Psychiatric Provider Evaluation



Last Name	First Name	AIS
DOB: / /	Race/Ethnicity:	Gender
<input type="checkbox"/> Routine <input type="checkbox"/> Urgent <input type="checkbox"/> Emergent <input type="checkbox"/> In-Person <input type="checkbox"/> Tele-Health		
Facility: Housing: <input type="checkbox"/> GP <input type="checkbox"/> Crisis <input type="checkbox"/> RTU <input type="checkbox"/> SU <input type="checkbox"/> RHU <input type="checkbox"/> Other:		

Reason for Evaluation and Chief Complaint

Present Problems and Symptoms

Review of Symptoms Yes No Comments

Review of Symptoms	Yes	No	Comments
Depression			
Mania			
Psychosis			
Anxiety			
Posttraumatic			
Cognitive			
Behavioral			
Other/Details:			

Psychiatric Treatment History (lifetime)

<input type="checkbox"/> Y <input type="checkbox"/> N Inpatient:
<input type="checkbox"/> Y <input type="checkbox"/> N Outpatient:
<input type="checkbox"/> Y <input type="checkbox"/> N MH Tx in jail:
Other info:

Medical History (pertinent)

Alabama Department of Correction
Psychiatric Provider Evaluation



History of Psychiatric Medications / Other Somatic Tx (lifetime)

<input type="checkbox"/> Y <input type="checkbox"/> N Antipsychotic
<input type="checkbox"/> Y <input type="checkbox"/> N Mood Stabilizer
<input type="checkbox"/> Y <input type="checkbox"/> N Antidepressant
<input type="checkbox"/> Y <input type="checkbox"/> N Anxiolytic
<input type="checkbox"/> Y <input type="checkbox"/> N Stimulant
<input type="checkbox"/> Y <input type="checkbox"/> N Hypnotic
<input type="checkbox"/> Y <input type="checkbox"/> N Other:
<input type="checkbox"/> Y <input type="checkbox"/> N Hx Adverse Drug Reactions
Prior AIMS (<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/A) Date: _____ Result: _____
Additional Info:

Suicidality and self-harm (lifetime history, including childhood) *Check all applicable items.*

<input type="checkbox"/> Y <input type="checkbox"/> N SRA completed today		<input type="checkbox"/> Y <input type="checkbox"/> N SRA previously completed on / /	
Suicide attempts (lifetime)	<input type="checkbox"/> Never	<input type="checkbox"/> Firearm	Other/Details:
	<input type="checkbox"/> Once	<input type="checkbox"/> Hanging	
	<input type="checkbox"/> Multiple times	<input type="checkbox"/> Asphyxiation	
	<input type="checkbox"/> Unreported	<input type="checkbox"/> Poisoning	
	<input type="checkbox"/> Emergency care	<input type="checkbox"/> Jumping	
	<input type="checkbox"/> Hospitalized	<input type="checkbox"/> Vehicle crash	
Non-suicidal self-harm	<input type="checkbox"/> Never	<input type="checkbox"/> Visible scars	Other/Details:
	<input type="checkbox"/> Cut/Scratch	<input type="checkbox"/> Provides relief	
	<input type="checkbox"/> Hit		
	<input type="checkbox"/> Burning		
	<input type="checkbox"/> Other		
Tempting fate	<input type="checkbox"/> Y <input type="checkbox"/> N (Actions with indifference to death):		
Other into			

Aggression and Harm to Others (lifetime history, including childhood) *Check all applicable items.*

Altercations / assaults	<input type="checkbox"/> No injuries	<input type="checkbox"/> No weapons	Other/Details:
	<input type="checkbox"/> Other injured	<input type="checkbox"/> Firearm used	
	<input type="checkbox"/> Fatal outcome	<input type="checkbox"/> Other weapon	
Fantasies of harming someone	<input type="checkbox"/> Current	<input type="checkbox"/> Persecutory	Other/Details:
	<input type="checkbox"/> Prior	<input type="checkbox"/> Obsessive	
	<input type="checkbox"/> Planned	<input type="checkbox"/> Has intent	
	<input type="checkbox"/> Acted	<input type="checkbox"/> Has means	

Alabama Department of Correction
Psychiatric Provider Evaluation



Social History (pertinent)

Substance Abuse/Addiction Treatment History (Lifetime)

<input type="checkbox"/> Y <input type="checkbox"/> N Outpatient tx/rehab
<input type="checkbox"/> Y <input type="checkbox"/> N Residential tx/rehab
<input type="checkbox"/> Y <input type="checkbox"/> N Overdose (accidental)
<input type="checkbox"/> Y <input type="checkbox"/> N Withdrawal symptoms
<input type="checkbox"/> Y <input type="checkbox"/> N Hx IVDA

Objective/ Mental Status Examination (Provide details)

Consciousness / Cognition	<input type="checkbox"/> Alert <input type="checkbox"/> Ox3
Appearance	<input type="checkbox"/> Good hygiene
Behavior/ Attitude	<input type="checkbox"/> Cooperative <input type="checkbox"/> Calm <input type="checkbox"/> Attentive
Speech:	<input type="checkbox"/> Coherent <input type="checkbox"/> NI Rate/Rhythm <input type="checkbox"/> Pressured <input type="checkbox"/> Rapid <input type="checkbox"/> Slow <input type="checkbox"/> Coherent
Mood/affect:	<input type="checkbox"/> Euthymic <input type="checkbox"/> Sad/down <input type="checkbox"/> Elevated <input type="checkbox"/> Irritable <input type="checkbox"/> Angry <input type="checkbox"/> Blunted/flat <input type="checkbox"/> Affect appropriate
Thought Content	<input type="checkbox"/> Appropriate <input type="checkbox"/> Over-valued ideas <input type="checkbox"/> Delusions <input type="checkbox"/> Obsessions <input type="checkbox"/> Impoverished
Thought Process	<input type="checkbox"/> Logical <input type="checkbox"/> Tangential <input type="checkbox"/> Loose associations <input type="checkbox"/> F.O.I. <input type="checkbox"/> Concrete
Harm Self/Others	Details:
Perception:	<input type="checkbox"/> Normal <i>Hallucinations:</i> <input type="checkbox"/> Auditory <input type="checkbox"/> Visual <input type="checkbox"/> Olfactory <input type="checkbox"/> Somatic <input type="checkbox"/> Tactile
Insight & Judgment	<input type="checkbox"/> Good insight <input type="checkbox"/> Partial insight <input type="checkbox"/> No insight <input type="checkbox"/> Judgment Intact
Neuro / EPS	AIMS Today (<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/A) Result:

Diagnosis (Use DSM-5 terminology)

--

Alabama Department of Correction
Psychiatric Provider Evaluation



Case formulation & Level of Function

Plan

Medication:
Lab Orders <input type="checkbox"/> N <input type="checkbox"/> Y
Psychotherapy/Counseling <input type="checkbox"/> N <input type="checkbox"/> Y If yes, to be provided by:
Consultation / Referral to Medical Service <input type="checkbox"/> N <input type="checkbox"/> Y
Patient Education <input type="checkbox"/> Diagnosis <input type="checkbox"/> Consent <input type="checkbox"/> Patient Info Fact Sheet (PIF)
Other:

Follow-up scheduled in:

SMI: <input type="checkbox"/> N <input type="checkbox"/> Y	MH-CODE: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D
---	---

Psychiatrist/NP Name/Credentials (Print):	Signature:	Date and Time: ____/____/____ @ ____:____ AM/PM
My signature verifies that I have interviewed and examined this individual in an <u>out-of-cell</u> setting that provides sound <u>confidentiality</u>. Explain any exceptions:		

**Alabama Department of Corrections
Psychiatric Provider Progress Note**



Last Name	First Name:	AIS:
DOB: / / Age:	<input type="checkbox"/> Routine <input type="checkbox"/> Urgent <input type="checkbox"/> Emergent	<input type="checkbox"/> In-Person <input type="checkbox"/> Tele-Health
Facility:	Housing: <input type="checkbox"/> GP <input type="checkbox"/> Crisis <input type="checkbox"/> RTU <input type="checkbox"/> SU <input type="checkbox"/> SLU <input type="checkbox"/> RHU <input type="checkbox"/> PHRU <input type="checkbox"/> WR	
MH Code: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D Last change: / /	SMI: <input type="checkbox"/> Y <input type="checkbox"/> N Last change: / /	

Target Problems and Symptoms:

Current Medications (MAR Reviewed Y N)

Adherence:	Adverse Drug Reactions / Allergies:		
Weight / BMI:	Date: / /	Last AIMS: (Date)	Consents: (Date)

S/ (narrative)

O/ Mental Status Examination *(Describe pertinent details.)*

Consciousness / Cognition	<input type="checkbox"/> Alert <input type="checkbox"/> Ox3 <input type="checkbox"/> Attentive
Appearance	<input type="checkbox"/> Good hygiene
Behavior/ Attitude	<input type="checkbox"/> Cooperative <input type="checkbox"/> Calm <input type="checkbox"/> Agitated
Speech:	<input type="checkbox"/> Coherent <input type="checkbox"/> NI Rate <input type="checkbox"/> Pressured <input type="checkbox"/> Rapid <input type="checkbox"/> Slow
Mood/affect:	<input type="checkbox"/> Euthymic <input type="checkbox"/> Sad/down <input type="checkbox"/> Elevated <input type="checkbox"/> Irritable <input type="checkbox"/> Angry <input type="checkbox"/> Blunted/flat <input type="checkbox"/> Affect appropriate
Thought Content	<input type="checkbox"/> Appropriate <input type="checkbox"/> Over-valued ideas <input type="checkbox"/> Delusions <input type="checkbox"/> Obsessions <input type="checkbox"/> Impoverished

**Alabama Department of Corrections
Psychiatric Provider Progress Note**



Harm	<input type="checkbox"/> None Suicide: <input type="checkbox"/> Ideation <input type="checkbox"/> Plan <input type="checkbox"/> Intent <input type="checkbox"/> Tempting fate NSSI: <input type="checkbox"/> Ideation <input type="checkbox"/> Plan <input type="checkbox"/> Intent Aggression: <input type="checkbox"/> Ideation <input type="checkbox"/> Intent
Thought Process	<input type="checkbox"/> Logical <input type="checkbox"/> Tangential <input type="checkbox"/> Loose associations <input type="checkbox"/> F.O.I. <input type="checkbox"/> Concrete
Perception:	<input type="checkbox"/> Normal <i>Hallucinations:</i> <input type="checkbox"/> Auditory <input type="checkbox"/> Visual <input type="checkbox"/> Olfactory <input type="checkbox"/> Somatic <input type="checkbox"/> Tactile If hallucinations, any command-type? <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N/A
Insight & Judgment	<input type="checkbox"/> Good insight <input type="checkbox"/> Partial insight <input type="checkbox"/> No insight <input type="checkbox"/> Y <input type="checkbox"/> N Judgment Intact
Neuro / EPS	<input type="checkbox"/> Y <input type="checkbox"/> N Current AIMS: / / / Other/Details:

Lab Review:	New results: <input type="checkbox"/> Y <input type="checkbox"/> N
--------------------	--

A/ (Use DSM-5 Diagnosis; Include differential diagnosis)
Formulation/Summary (Include risk assessment)

P/ Include Rx and lab orders)
Patient Education: <input type="checkbox"/> Diagnosis <input type="checkbox"/> Consent Form <input type="checkbox"/> Patient. Info Fact sheet (PIF)
Referrals <input type="checkbox"/> NP <input type="checkbox"/> LBHP <input type="checkbox"/> BH Nurse <input type="checkbox"/> Medical <input type="checkbox"/> Other <input type="checkbox"/> None
Reason for referral(s):
Return visit in:

Psychiatrist / NP: (Print)	Sign:
My signature verifies this person was seen out-of-cell in a setting that provided sound confidentiality. Note any exceptions:	

Date: / /	Start time: :	AM PM	End Time: :	AM PM
----------------------	----------------------	--------------	--------------------	--------------

