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|  | ALASKA DEPARTMENT OF CORRECTIONS |

**THIRD-PARTY PSYCHIATRIST INVOLUNTARY MEDICATION EVALUATION FORM 807.16C**

**DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

### Prisoner Information

|  |  |  |  |
| --- | --- | --- | --- |
| Prisoner Name: |  | OBSCIS: |  |

|  |
| --- |
| Presenting Symptoms |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Current Behavior, signs and symptoms exhibited which support referral for involuntary medication: | | | | |
| Is the behavior described above a direct  consequence of the offender’s mental illness? |  | Yes |  | No |
| Clinical Rationale: | | | | |

### Mental Health

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Mental Health History: | | | | |
| Current mental status exam and suicide/homicide risk: | | | | |
| Any impairment in activities of daily living? |  | Yes |  | No |
| Clinical Rationale: | | | | |

### Diagnosis

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Axis I | | | | | |
| Axis II | | | | | |
| Axis III | | | | | |
| Comments: | | | | | |
| Imminent risk of harm to self? |  | Yes |  | | No |
| Clinical Rationale: | | | | | |
| Imminent risk of harm to others? |  | Yes | |  | No |
| Clinical Rationale: | | | | | |
| Imminent risk to harm self/others due to grave disability? |  | Yes |  | | No |
| Clinical Rational | | | | | |
| Is offender capable to give informed consent regarding medication? |  | Yes |  | | No |
| Clinical Rationale: | | | | | |
| Describe less restrictive alternative forms of treatment considered/attempted: | | | | | |

### Medication Recommendations

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Voluntary and involuntary medication history (include response, side effects): | | | | |
| Would offender continue taking medication  without an involuntary medication order? |  | Yes |  | No |
| Clinical Rationale: | | | | |
| Agree with treating psychiatric provider’s recommendation? |  | Yes |  | No |
| Clinical Rationale: | | | | |
| Based on current behavior, sign, and symptoms what medications are recommended? | | | | |
| What are the potential side effects and/or risks of the recommended medication? | | | | |
| What are the potential benefits of the recommended medication? | | | | |

### Signatures

It is my medical opinion that the benefits anticipated from the recommended involuntary medication substantially outweigh the potential risks and/or side effects.

|  |  |  |
| --- | --- | --- |
| Name | Title | Date |
|  |  | Click here to enter a date. |