

BP-A351_MEDICAL/PSYCHOLOGICAL PRE-RELEASE EVALUATION

MEDICAL/PSYCHOLOGICAL PRE-RELEASE EVALUATION

Name	Register Number	Date
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Unit Manager	Ext.:	Expected date of transfer/release
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A. Mental Health Status <input type="checkbox"/> 1. No evidence of mental problems. <input type="checkbox"/> 2. **History of mental health problems; no current symptoms; no follow up care needed. <input type="checkbox"/> 3. **Mild or recurring mental health problems managed without medication; may require periodic intervention and supervision. <input type="checkbox"/> 4. **Mental health problems under control with medication; needs follow up and supervision. <input type="checkbox"/> 5. **Mental health problems; noncompliant with recommended treatment; will need close monitoring and follow up care. <input type="checkbox"/> 6. **Is in the process of diagnostic evaluation or specific treatment. ** List diagnoses and explain in layman's term.	B. Medical Status <input type="checkbox"/> 1. Healthy with no evidence of significant medical problems. <input type="checkbox"/> 2. **Minor medical problems only. <input type="checkbox"/> 3. **Has significant medical disorder; under good control and will require follow up care. <input type="checkbox"/> 4. **Has one or more chronic or recurrent medical problems. <input type="checkbox"/> 5. **Has an uncontrolled significant disorder. <input type="checkbox"/> 6. **Is in the process of diagnostic evaluation or specific treatment. ** List diagnoses and explain in layman's term.
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Mental Health Remarks:	Medical Remarks:

<input type="checkbox"/> Transfer recommended	<input type="checkbox"/> Transfer NOT recommended	<input type="checkbox"/> Transfer recommended	<input type="checkbox"/> Transfer NOT recommended
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Psychologist/Psychiatrist (BOP staff only) _____ Date _____	Medical Officer (or Designee) _____
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C. Dental Status: No evidence of significant dental problems.
 In process of evaluation and treatment. Completion Date: _____

<input type="checkbox"/> Transfer recommended	<input type="checkbox"/> Transfer NOT recommended	Dental Officer (or Designee) _____	Date _____
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D. Chronic Medications/Special Needs (i.e., equipment, diet)

1. _____	5. _____
2. _____	6. _____
3. _____	7. _____
4. _____	8. _____

IS INMATE ON DEA CONTROLLED MEDICATION(S)? No Yes - IF YES, UNIT STAFF MUST CONTACT CCM OFFICE

TB CLEARANCE: PPD Completed: Date _____	Results: _____ mm
CXR Completed: Date _____	Results: _____

INSTRUCTIONS FOR COMPLETION OF THE BPS-351 ON BACK OF FIRST PAGE

I. The form will be routed/completed in the following order after initiation by unit staff:

- A. Psychology/Psychiatric Services
- B. Health Services
- C. Dental Services
- D. Completed only if transfer is recommended

The form is to be returned at any point that a transfer is not recommended or at the completion of Section D.

II. CCC placement requires careful consideration of an inmate's mental health and medical concerns. Through Form BP-S351, psychology and medical services can help institutional and community corrections staff make good decisions on CCC referrals and placement. The purpose of this form is:

to recommend against community-based programming for inmates who have mental health or medical problems and are not appropriate for CCC facilities: and

to convey critical mental health or medical information to community corrections staff for inmates who are recommended for transfer to a CCC.

The following grid is a guideline (**only**) for psychology and medical staff to use in completing BP-S351. Staff should review all available documentation on the inmate and use their clinical judgement in choosing one category over another, in making CCC placement decisions, and in the type of information that needs to be communicated to CCC staff. Staff are to choose the category that best describes the inmate at the **expected date of transfer/release**.

Categories	Remarks Section	Helpful Hints
1.	No remarks necessary.	None
2.	Brief Remarks on diagnosis and possible mental health or medical concerns in community (if known).	Focus remarks on issues relevant to CCM and halfway house staff.
3.	Brief Remarks on diagnosis and recommended treatment services or follow up in the community.	Focus remarks on issues relevant to CCM and halfway house staff.
4.	Brief Remarks on diagnosis, medication, and any identified issues that may surface at community placement.	Focus remarks on issues relevant to CCM and halfway house staff.
5.	NOTE "DO NOT RECOMMEND CCC TRANSFER" on form.	Write down rationale for denial in remarks section and/or contact unit team directly.
6.	NOTE "DO NOT RECOMMEND CCC TRANSFER" on form.	Write down rationale for denial in remarks section and/or contact unit team directly.