

Inmate Medical/Mental Health Information Form

Print Clearly & Use Reverse Side As Needed

INMATE INFORMATION

Inmate's Full Legal Name: _____

Date Of Birth: _____ Booking # _____

SOURCE OF INFORMATION FOR THIS FORM:

Your Name: _____

Relationship: Professional ___ Family ___ Friend ___ Other ___ (Describe: _____)

Daytime Phone: _____ Evening Phone: _____

SIGN HERE: _____

TREATMENT HISTORY BY VENTURA COUNTY BEHAVIORAL HEALTH DEPARTMENT (VCBH)

Presently VCBH Client: Yes ___ No ___ Unknown ___ Date Last Treated: _____

Last VCBH Clinic _____ Last VCBH Doctor _____

PHYSICIAN/TREATMENT FACILITY/OTHER MEDICAL/MENTAL HEALTH PROVIDERS

(___ check here if using reverse side for more than one provider)

Name: _____ Date Last Treated: _____

Phone: _____ Fax: _____

PHARMACY Name: _____ Phone: _____ Fax: _____

MENTAL HEALTH INFORMATION

Diagnoses: _____

Current Medications (Name, Dosage, Frequency & Date Started): _____

Last Time Medications Taken (if Known): Date: _____ Time: _____

Medication Compliance? Yes ___ No ___ Partial ___

Adverse Effects of Medications (i.e. side effects, allergies, poor efficacy): _____

Prior Helpful Medications? Why Discontinued? _____

Is Suicide a Concern? No ___ Yes ___ If yes, why? (include prior attempts) _____

OTHER CONDITIONS, INCLUDING ALLERGIES, OR ADDITIONAL MEDICAL/MENTAL HEALTH INFO:

___ Check here if CONFIDENTIALITY WAIVER BY INMATE accompanies this form