**AMPM Policy 1020, Exhibit 1020-1 Psychiatric security review board/GEI Conditional Release Monthly Report**

**Any violation of the Conditional Release, psychiatric decompensation or use of alcohol, illegal substances or prescription medication not prescribed to the patient shall be reported to the PSRB *immediately*.**

**Report for the month of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year: \_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Demographics | | | | | | | | | | | |
| Name: | | | | Date of Birth: | | | | | | | |
| Current Psychiatric Diagnosis: | | | | | | | | | | | |
| Crime: | | | | | | | | | | | |
| Sentence: | | | | | Sentence Expiration: | | | | | | |
| Patient Address:  ZIP Code: | | | | | | | | | | | |
| Residence phone: | | | | | Personal Phone : | | | | | | |
| Type of placement Residence:  Monthly payment or rent:  How long? | | | | | | | | | | | |
| AzSH Admission Date: | | Last AzSH Discharge Date: | | | | Number AzSH Admissions: | | | | | |
| Contacts | | | | | | | | | | | |
| Contractor, T/RBHA: | | | | | | | | | | | |
| Primary Behavioral Health Provider Name: | | | | | | | | | | | |
| County: | | | Phone: | | | | Fax: | | | | |
| Full Provider Address:  State:  ZIP Code: | | | | | | | | | | | |
| Case Manager: | Email: | | | | | | | Phone: | | | |
| Compliance with the Standard Conditions of Release | | | | | | | | | | | |
| Answer all questions and provide explanatory comments for each section when potential concern is indicated. ***All Non-Compliant responses require comment*** | | | | | | | | | Compliant | Non-Compliant | |
| 1. Cooperating with all treatment recommendations | | | | | | | | | ☐ |  | |
| 1. Keeping all required appointments | | | | | | | | |  |  | |
| 1. Providing personal and employer contact information to the PSRB | | | | | | | | |  |  | |
| 1. Not violating any local / state/ federal law | | | | | | | | |  |  | |
| 1. Not using/possessing drugs, alcohol or toxic vapors | | | | | | | | |  |  | |
| 1. Not leaving residence for more than 24 hours without the approval of the treating psychiatrist | | | | | | | | |  |  | |
| 1. Not leaving residence for more than 72 hours or left the state of Arizona without the approval of the PSRB | | | | | | | | |  |  | |
| 1. Not changing his/her residence without the approval of the PSRB | | | | | | | | |  |  | |
| 1. Not possessing weapons | | | | | | | | |  |  | |
| 1. Adhering to restrictions on contacting victims | | | | | | | | |  |  | |
| Click here to enter text. | | | | | | | | | | | |
| Overall Impression of Patients Compliance with approved PSRB Conditional Release Plan ( CR PLAN) | | | | | | | | | | | |
| Fully Compliant  Partially Compliant  Non-Compliant  Phone: | | | | | | | | | | | |
| Click here to enter text. | | | | | | | | | | | |
| **Psychiatric Presentation** | | | | | | | | | | | |
|  | | | | | | | | | Yes | | No |
| Has there been any crisis or signs of decompensation since the last monthly report? | | | | | | | | |  | |  |
| Has there been any need of outreach interventions to maintain the patient in treatment? | | | | | | | | |  | |  |
| Has the patient presented any signs OR made any statements of DTS/DTO? | | | | | | | | |  | |  |
| If yes to any of the above questions, please provide the date PSRB and AHCCCS were immediately notified \_\_/\_\_/\_\_\_\_ | | | | | | | | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Answer all questions and provide explanatory comments for each section when potential concerns are indicated.** | | | |
| Individualized Conditions of Release | | | |
| List the specific conditions of release | | | |
| Click here to enter text. | | | |
|  | | Yes | No |
| 1. Has the patient complied with ALL residence conditions outlined in the approved CR PLAN? | |  |  |
| 1. Has the patient’s residence contacted the clinical team with any concerns? | |  |  |
| 1. Has the treatment team spoken with staff/family members at the residence? | |  |  |
| Click here to enter text. | | | |
| Psychiatric Treatment and Monitoring *(please attach the psychiatrist’s progress notes for this reporting period to this report)* | | | |
|  | | Yes | No |
| 1. Has the patient complied with ALL psychiatric treatment conditions outlined in the approved CR PLAN? | |  |  |
| 1. Dates of psychiatric visits this month: | | | |
| Medications and Monitoring (please attach the psychiatrist’s progress notes for this reporting period to this report) | | | |
| List all current medications including dosage and frequency: | | | |
| Click here to enter text. | | Yes | No |
| 1. Have there been any problems obtaining psychotropic medications for the patient? | |  |  |
| 1. Have there been any changes in medication since the last report? | |  |  |
| 1. Does the patient take medication independently? If so, how is medication adherence and medication   supply monitored? Document in the comments section below | |  |  |
| Click here to enter text. | | | |
| Outpatient Provider | | | |
|  | | Yes | No |
| Has the patient complied with ALL Outpatient Provider conditions outlined in the approved CR PLAN? | |  |  |
| Click here to enter text. | |  |  |
| Case Management | | | |
|  | | Yes | No |
| 1. Has the patient complied with ALL case management conditions outlined in the approved CR PLAN? | |  |  |
| 1. Dates of case management contact this month: | | | |
| Click here to enter text. | | | |
| Contractor Monitoring | | | |
|  | | Yes | No |
| Has the patient complied with ALL Contractor monitoring conditions outlined in the CR PLAN? | |  |  |
| Click here to enter text. | | | |
| Employment/Education/Volunteering | | | |
|  | | Yes | No |
| 1. Is the patient volunteering, employed or attending school? | |  |  |
| 1. If yes, please provide the name and address and hours per week spent on volunteering/employment/education. | | | |
| Click here to enter text. | | | |
| Community Meetings | | | |
|  | | Yes | No |
| 1. Has the patient complied with ALL community meeting(s) conditions outlined in the approved CR PLAN? | |  |  |
| 1. Dates of community meetings this month. | | | |
| Click here to enter text. | | | |
| Substance Use Testing *(please attach the substance testing laboratory records for this reporting period to this report)* | | | |
|  | | Yes | No |
| 1. Has the patient complied with ALL random, unannounced substance testing conditions outlined in the approved CR PLAN? | |  |  |
| 1. Date(s) of substance testing this month | | | |
| 1. Was any drug screen positive this month? | |  |  |
| Ifyes**,**  what date was the PSRB notified of positive drug screen? | | | |
| Click here to enter text. | | | |
| Therapeutic Interventions | | | |
|  | | Yes | No |
| 1. Has the patient complied with ALL therapeutic intervention conditions outlined in the approved CR PLAN? | |  |  |
| 1. Dates of therapy and other therapeutic interventions this month: | | | |
| Click here to enter text. | | | |
| Victim Contact Conditions | | | |
|  | | Yes | No |
| Has the patient complied with ALL victim contact conditions outlined in the approved CR PLAN? | |  |  |
| Click here to enter text. | | | |
| Return via Email by the 5th of the month to | | | |
| Jaime.Shapiro@azdhs.gov  No | | | |
| Medicalmanagement@azahcccs.gov | | | |
| Patient’s Attorney Name and email address: | | | |
| **Reporter Information:** | | | |
| Name of Person Completing Report: | DATE: | | |
| Title of Person Completing Report: | | | |
| Name of Treating Psychiatrist: | | | |
| Name of Health Plan Reviewer: | | | |