**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? |[x] [ ]
| 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?
 |[x]  [ ]  |
| 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.govNo |
| 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:  |