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

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| **Member Name:** |  |
| **Date *(MM/YYYY)*:** |  |

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| **Demographics** | | | | | | | | | | |
| Name: | | | | | | AHCCCS ID# | | | | |
| Date of Birth: | | Current Psychiatric Diagnosis:  Phone: | | | | | | | | |
| Crime: | | | | | | | | | | |
| Sentence: | | | | | | | Sentence Expiration:  ZIP Code: | | | |
| Patient Address:  Monthly payment or rent:  How long? | | | | | | | | | | |
| Residence phone: | | | | | | | Personal Phone :  ZIP Code: | | | |
| Type of Placement:  Monthly payment or rent:  How long? | | | | | | | | | | |
| AzSH Admission Date: | | | | Last AzSH Discharge Date: | | | | Number AzSH Admissions: | | |
| **Contacts** | | | | | | | | | | |
| Contractor, RBHA: | | | | | | | | | | |
| Primary Behavioral Health Provider Name:  How long? | | | | | | | | | | |
| County: | | | | | Phone: | | | | Fax: | |
| Full Provider Address:  State:  ZIP Code: | | | | | | | | | | |
| Case Manager: | | | Email: | | | | | | | Phone: |
| **Member Name:** | |  | | | | |
| **Date *(MM/YYYY)*:** | |  | | | | |

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| **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. | | |

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| ***Member Name:*** |  |
| ***Date (MM/YYYY):*** |  |

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| **Psychiatric Presentation** | | | |
| Provide a narrative summary of the patient’s psychiatric presentation.  Click here to enter text. | | | |
|  | 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 \_\_/\_\_/\_\_\_\_ | | | |
| Click here to enter text. | | | |
| **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. | | | |

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| ***Member Name:*** |  |
| ***Date (MM/YYYY):*** |  |

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| **Psychiatric Treatment And Monitoring (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 CRP? |  | |  |
| 1. Dates of psychiatric visits this month: | | | |
| Click here to enter text. | | | |
| **Medications and Monitoring** | | | |
| 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   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. | |  |  |

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| ***Member Name:*** |  |
| ***Date (MM/YYYY):*** |  |

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| **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. | | |

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| ***Member Name:*** |  |
| ***Date (MM/YYYY):*** |  |

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| **Substance Use Testing**  **(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** | | | | |
| Enter contact restrictions.  Click here to enter text. | | Yes | | No |
| Has the patient complied with ALL victim contact restrictions outlined in the approved CR Plan? | |  | |  |
| Click here to enter text. | | | | |
| **Return Via Email By The 5th Of The Month To** | | | | |
| psrb@azhs.gov | | | | |
| Medicalmanagement@azahcccs.gov | | | | |
| Patient’s Attorney Name and email address: | | | | |

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| ***Member Name:*** |  |
| ***Date (MM/YYYY):*** |  |

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| **Reporter Information:** | | | |
| Name of Provider Case Manager Completing Report: | | | Date: |
| Title Provider Case Manager: | | | |
| 1. I have included monthly prescriber treatment note and results of required lab testing, where applicable; 2. I have verified the member’s attendance in treatment requirements not solely on the report of the client; 3. I have reported all non-compliance with the Board’s order, either in this report or separately in writing, all significant incident(s) and/or change(s) in mental health status since the last monthly report; and 4. I have verified that all services were provided to the client as required in the Board’s order/treatment plan, or I have explained in this report why services were not provided. | | | |
| By Signing I am attesting the above to be true:  Provider Case Manager Signature: | | Date: | |
| Name of Attending Practitioner: | | | |
| Name of Contractor Care Manager: | Date: | | |