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 Arizona Psychiatric Security Review Board (PSRB) *immediately*.

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| **REPORT FOR THE MONTH OF** |  | **YEAR** |  |
| **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? | | | | | |
| ASH Admission Date: | | Last ASH Discharge Date: | | | Number ASH Admissions: |

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| **CONTACTS** | | | | |
| Contractor | | | | |
| Primary Behavioral Health Provider Name:  How long? | | | | |
| County: | | Phone: | Fax: | |
| Full Provider Address:  State:  ZIP Code: | | | | |
| Case Manager: | Email: | | | Phone: |

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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. | | |

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| **OVERALL IMPRESSION OF PATIENT COMPLIANCE WITH APPROVED PSRB CONDITIONAL RELEASE PLAN (CRP)** |
| Fully Compliant  Partially Compliant  Non-Compliant  Phone: |
| Click here to enter text. |

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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 Danger to Self(DTS)/Danger to Others (DTO)? |  |  |
| If yes to any of the above questions, please provide the date PSRB and AHCCCS were immediately notified \_\_/\_\_/\_\_\_\_ | | |
| Click here to enter text. | | |

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| **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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| **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. | | | |

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| **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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| **CASE MANAGEMENT** | | |
|  | Yes | No |
| 1. Has the patient complied with ALL case management conditions outlined in the approved CR Plan? |  |  |
| 1. Dates of provider case management contact this month: | | |
| Click here to enter text. | | |

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| **CONTRACTOR MONITORING** | | |
|  | Yes | No |
| Has the patient complied with ALL Contractor monitoring conditions outlined in the CR Plan? |  |  |
| Date of, and type/location of Contractor Care Manager outreach with the member during the month (face to face, teleconference, provider office, etc.): | | |
| Date on which the Contractor attended staffing for the member during the month: | | |

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| **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. | | |

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| **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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| **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. | | |

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| **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. | | |

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| **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. | | |

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| **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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| **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: | | |