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

|  |  |
| --- | --- |
| **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 ReleaseClick 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: |