North Kern State Prison
Inmate Mental Health Information Form

The **Inmate Mental Health Information Form** is provided below. Print and complete the form and either fax it or mail it to North Kern State Prison.

- Fax number: (661) 721-6262
- Address:

Dr. Greg Hirokawa, Chief Psychologist
North Kern State Prison
P.O. Box 567
Delano, CA 93216-0567

If this form is not available, you can still provide us with information about your family member's mental health and medical history. When sending information to North Kern State Prison, please include as much as you can of the following information regarding your family member:

- Full name
- Date of birth
- Diagnosis (include both current and past diagnoses if possible)
- Psychiatrist/ psychologist/ counselor's phone number and address
- Medications currently prescribed (along with dosage)
- Prescribing physician's name, address and phone number
- Problems with medications in the past
- History of suicide attempts/threats: provide a description of events if you can
- Your concerns about the possibility that the inmate might harm himself
- History of psychological difficulties, other than self-harm
- Any other urgent medical conditions that might require immediate attention – include doctor's names, addresses and phone numbers if you have those available to you

The mental health and medical information you provide is tremendously valuable in making an assessment and will help mental health staff at North Kern State Prison select the best treatment for your relative. There is a clear preference for maintaining effective current treatment. However, the prison staff must conduct its own assessment of your relative's condition and may not necessarily prescribe exactly the same medications.

North Kern State Prison is prohibited by law from giving anyone information about an inmate's mental or physical health unless they have consent from the inmate. However, the staff can receive information from relatives or friends without consent. The inmate will have access to the information you provide on this form. **The background information you provide can be extremely helpful for your loved one, who may have difficulty providing accurate information regarding his mental health concerns.**

INMATE MENTAL HEALTH INFORMATION FORM

INMATE INFORMATION

FULL LEGAL NAME:______________________________ BIRTHDATE: ______________

ADDRESS BEFORE PRISON:______________________________

CDCR #:______________ HOUSING, IF KNOWN: ______________________________

FAMILY CONTACT INFORMATION

THIS FORM IS BEING COMPLETED BY:______________________________

FAMILY MEMBER WHO CAN BE CONTACTED REGARDING THIS FORM:______________________________

RELATIONSHIP TO INMATE:______________________________

ADDRESS:______________ CITY:______________ STATE/ ZIP:______________

DAYTIME PHONE:______________ EVENING PHONE:______________ CELL:______________

MENTAL HEALTH INFORMATION

PSYCHIATRIST INFORMATION:

NAME:______________ ADDRESS:______________

PHONE:______________ APPROXIMATE DATES OF TREATMENT:______________

PSYCHOLOGIST/ COUNSELOR INFORMATION:

NAME:______________ ADDRESS:______________

PHONE:______________ APPROXIMATE DATES OF TREATMENT:______________

DESCRIBE THE INMATE'S MENTAL HEALTH HISTORY:______________________________

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____

DIAGNOSIS:______________________________

MEDICATIONS:______________________________

Side effects or negative reactions to medications:______________________________

ARE YOU WORRIED THAT THE INMATE MIGHT HARM HIMSELF? ☐ NO ☐ YES

If yes, explain your concerns:______________________________

HAS YOUR FAMILY MEMBER ATTEMPTED SUICIDE IN THE PAST? ☐ NO ☐ YES

If yes, provide approximately date(s) and number of suicide attempts/threats:______________

What was going on that might have triggered suicidal thoughts or behavior?______________

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MEDICAL INFORMATION

MEDICAL DOCTOR:

NAME:______________ ADDRESS:______________

PHONE:______________ APPROXIMATE DATES OF TREATMENT:______________

LIST MEDICAL CONCERNS:______________________________

____

MEDICATIONS:______________________________

NORTH KERN STATE PRISON CONTACT INFORMATION

PLEASE FAX OR MAIL THIS FORM TO: Mental Health Department

ADDRESS: NORTH KERN STATE PRISON/ P.O. BOX 567/ DELANO, CALIFORNIA 93216-0567 *or* **FAX: (661) 721-6262**

NOTE: If you have any additional information you'd like to share, please attach a separate sheet. Thank you for your assistance!

This form was developed with the assistance of NAMI California