

OKLAHOMA DEPARTMENT OF CORRECTIONS

Correctional Center

INVOLUNTARY MEDICATION REPORT

(To be completed by Psychiatrist)

Inmate Name: _____ ODOC Number: _____

Psychiatric evaluation reveals that the above inmate has been diagnosed with a serious mental illness.

Mental History: _____

Current Mental Status Examination: _____

Diagnosis: (DSM)

_____As a result of this serious mental illness, the inmate has been assessed as presenting a substantial likelihood of:
(Check all that apply)☐ Danger to self as evidenced by: __________
_____☐ Danger to others as evidenced by: __________
_____☐ Substantial risk of significant property damage that may result in harm to self/others as evidenced by:_____

_____☐ Gravely disabled person as evidenced by: __________

Based on this psychiatric assessment, I have recommended to the inmate that the following medication(s) is required to treat his/her condition:

| Name of Medication(s) | Dose | Frequency | Route |
|-----------------------|-------|-----------|-------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

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(To be completed by Psychiatrist)

Inmate Name: _____ **ODOC Number:** _____

The inmate has refused to accept the prescribed medication(s) or lacks capacity to give informed consent. The following efforts have been made for the inmate to voluntarily accept the medication with these results:

Based on this situation, I am requesting that involuntary medication be administered to this inmate.

This is an: (*Check appropriate box*)

- ☐ Initial Request, OR
☐ Continuation Request after:
☐ 30 days since last hearing
☐ 180 days since last hearing

Current response to involuntary medication: (*Continuation request only*) _____

Less intrusive alternatives to involuntary medication(s) considered and reason for rejection: _____

Religious objection to medication: (*Describe*) _____

History of side effects of the prescribed medication(s) are as follows: _____

Gains anticipated from the proposed involuntary medication(s): (*specify*) _____

In conclusion, it is my medical opinion that the gains anticipated from the proposed involuntary medication(s) substantially outweigh the risks of potential side effects.

Psychiatrist Signature: _____ **Date:** _____

Deliver to facility head's office on date signed.

CC: Medical File

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