

OKLAHOMA DEPARTMENT OF CORRECTIONS

Correctional Center

Medication Review Committee Report

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

In accordance with the Department of Corrections Procedure, OP-140652 entitled "Involuntary Psychotropic Medication in Non-Emergency Situations," the Medication Review Committee has reviewed the information presented at the administrative hearing regarding the above-referenced inmate. The hearing was conducted on _____.

_____ was assigned as the inmate's staff representative and assisted the inmate with this hearing. Notice of hearing was given to the inmate on _____. Attached is a copy of the notice of the hearing.

I.	<u>Investigation</u>
	The Medication Review Committee has considered the following information as documented in the inmate's medical file.
A.	The results of a psychiatric examination reflecting the inmate's mental status
	<input type="checkbox"/> Yes <input type="checkbox"/> No
B.	The inmate's DSM diagnosis
	<input type="checkbox"/> Yes <input type="checkbox"/> No
C.	The inmate's individualized treatment plan
	<input type="checkbox"/> Yes <input type="checkbox"/> No
D.	The medication and dosage prescribed for the inmate by the treating Psychiatrist
	<input type="checkbox"/> Yes <input type="checkbox"/> No
E.	Signs, symptoms, and behaviors observed by mental health staff indicating that one or more of the follow apply: (<i>check each that apply</i>):
	<input type="checkbox"/> There is a substantial likelihood of serious physical harm to self.
	<input type="checkbox"/> There is a substantial likelihood of serious physical harm to others.
	<input type="checkbox"/> There is a substantial risk of significant property damage that may result in harm to self/others.
	<input type="checkbox"/> The inmate is gravely disabled and is unable to care for themself so that their health and safety is endangered.
	<input type="checkbox"/> The inmate is gravely disabled and is incapable of participating in any treatment plan that would offer the inmate a realistic opportunity to improve their condition and alleviate physical suffering and/or further deterioration.
	Inmate Name: _____ ODOC Number: _____

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II. Record of the hearing

- A. Date of hearing: _____ Time of hearing: _____ A.M./P.M.
- B. Inmate [] **was** [] **was not** in attendance. If not, state reason(s) inmate was not in attendance: _____

- C. The following evidence in support of the recommendation of involuntary medication was presented at the hearing. _____

- D. Cross-examination conducted by or on behalf of the inmate (if cross-examination was not permitted or was limited, state reason(s)): _____

- E. Statement by the inmate and/or staff representative (list on separate page if necessary):

- F. Evidence presented by the inmate. Attach additional pages if necessary. (If the inmate was not permitted to present evidence or the Committee limited the evidence presented, state reason(s)): _____

- G. The staff representative acknowledges that the record of the hearing, as recorded above, accurately reflects what took place at the hearing.

Printed name of Staff Representative: _____

Signature of Staff Representative: _____

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

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III. Decision

The Medication Review Committee consisting of Committee Chairperson _____,
 _____, Psychologist _____,
 Physician/Psychiatrist _____, and _____,
 _____, find that (check all that apply):

1. A. ☐ Without medications, continued decompensation of the inmate's mental health is likely, thus presenting a substantial risk of serious harm to himself.
- B. ☐ Without medications, continued decompensation of the inmate's mental health is likely, thus presenting a substantial risk of serious harm to others.
- C. ☐ Without medications, continued decompensation of the inmate's mental health is likely, thus presenting a substantial risk the inmate will cause significant property damage, which may result in harm to self/others.
- D. ☐ Without medications, continued decompensation of the inmate's mental health is likely, thus presenting a substantial likelihood that the inmate will be unable to care for themselves so that their health and/or safety is endangered.
- E. ☐ Without medications, continued decompensation of the inmate's mental health is likely, thus presenting a substantial likelihood that the inmate would be incapable of participating in any treatment plan which would offer the inmate a realistic opportunity to improve their condition and would experience physical suffering and/or further deterioration.

List evidence relied upon in support of the above findings:

THEREFORE, pursuant to and in accordance with the Department of Corrections procedure, OP-140652 entitled "Involuntary Psychotropic Medication in Non-Emergency Situations," the Medication Review Committee adopts the recommendation that _____ is to be involuntarily medicated, and that _____ is to comply with this committee's decision to administer psychotropic medication.

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

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Medication Review Committee Signature	Approve	Disapproved	Date
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatrist/Physician	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
CHSA/Designee	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Administrative/Security Representative	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

_____ Medication Review Committee Chairperson (Psychologist)	_____ Date
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2. The Committee does not adopt the recommendation that _____, DOC Number _____, receive involuntarily administered medication.

_____	_____
Medication Review Committee Chairperson	Date

Any appeal of this decision will be made in writing to the Medication Review Committee Chairperson within 24 hours of the inmate's notification of the decision. The staff representative that assisted the inmate at the hearing will be available to assist in an appeal to a Psychiatrist designated by the Chief Mental Health Officer.

A copy of this report has been reviewed within one working day of the date and time of the hearing by: _____, Facility Head, _____ date.

A copy of this report was delivered to the above inmate within one working day of the facility head's review by:

_____	_____	_____
Printed Name	Signature	Position

Date: _____ Time: _____

cc: Facility Head
 Inmate
 Medical File
 Chairperson
 Psychiatrist

Inmate Name: _____ ODOC Number: _____