

Outpatient Competency Restoration Program (OCRP) Clinical Screening

Identifying Information				
DEFENDANT'S NAME	CAUSE NUMBER(S)			
ORDERING COURT	DATE OF COMPETENCY EVALUATION ORDER			
Disclaimer				
<p>This is a screening tool to consider relevant clinical factors for admission to OCRP. The information utilized to conduct this screening is not considered a complete record of all material related to a potential client. This is a screening of whether reported, historical factors may impact an individual's ability to successfully participate in competency restoration in an outpatient setting. The materials reviewed are not sufficient for any comprehensive determination of risk to public safety or to predict future risk or behaviors; such determinations are made by the court with jurisdiction over the matter. This screening is used by the Forensic Navigators as one piece (in addition to current court evaluations, assessment from meeting with the individual one-on-one, etc.) of the Recommended Services Plan submitted to court.</p>				
Clinical Screening Assessment				
PRESENT	PARTIALLY PRESENT	NOT PRESENT	NO INFORMATION	CLINICAL FACTORS CONSIDERED
Eligibility Criteria				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reported willingness to adhere to prescribed medications. Comments:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reported willingness to abstain from non-prescribed drugs and alcohol. Comments:
Rule Out Criteria				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reported to be experiencing chemical dependency detoxification and has issues with medical stability related to chemical detoxification. Comments:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reported current suicidal ideation with intent or plan. Comments:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reported current psychiatric symptoms at a severity that suggests that the defendant will not be able to care for their basic needs of health and safety in the community even with outpatient support services. Comments:
Potential Barriers				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reported to have one or more prior suicide attempts that required significant medical treatment and/or family history of suicide completion. Comments:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reported recent history of harming others. Comments:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reported history of significant physical assault within institutions such as jails, psychiatric centers, and hospitals within past three (3) months. Comments:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reported history of absconding from treatment programs. Comments:

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reported history of non-adherence to potential outpatient mental health treatment or conditions of release. Comments:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reported to have a history of multiple relapses of substance abuse. Comments:
Records Reviewed				
<input type="checkbox"/> FN Case logs <input type="checkbox"/> Evaluation report <input type="checkbox"/> Criminal history <input type="checkbox"/> Court order <input type="checkbox"/> Jail records <input type="checkbox"/> Other (list):				
PERSON COMPLETING FORM				DATE FORM COMPLETED