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|  |  BEHAVIORAL HEALTH ADMINISTRATION (BHA) OUTPATIENT COMPETENCY RESTORATION PROGRAM (OCRP) **OCRP Discharge Summary** |
| **Identifying and Contact Information at the Time of Program End** |
| PERSON’S NAME      | EMAIL ADDRESS      | PHONE NUMBER (WITH AREA CODE)(     )       |
| CAUSE NUMBER(S)      |
| STREET ADDRESS CITY STATE ZIP CODE                     |
| **Section 1. Points of Contact** |
| OCRP PROVIDER      | PHONE NUMBER (WITH AREA CODE)(     )       |
| FORENSIC NAVIGATOR      | PHONE NUMBER (WITH AREA CODE)(     )       |
| FHARPS PROVIDER OR [ ]  N/A      | PHONE NUMBER (WITH AREA CODE)(     )       |
| FPATH PROVIDER OR [ ]  N/A      | PHONE NUMBER (WITH AREA CODE)(     )       |
| OUTPATIENT BEHAVIORAL HEALTH PROVIDER AND CASE MANAGER / THERAPIST      | PHONE NUMBER (WITH AREA CODE)(     )       |
| OUTPATIENT SUBSTANCE USE DISORDER PROVIDER AND CASE MANAGER / THERAPIST      | PHONE NUMBER (WITH AREA CODE)(     )       |
| LEGAL REPRESENTATIVE – DEFENSE COUNSEL      | PHONE NUMBER (WITH AREA CODE)(     )       |
| OTHER SUPPORT / SERVICE PROVIDER AND CONTACT PERSON (PLEASE LIST SUPPORT / SERVICE)      | PHONE NUMBER (WITH AREA CODE)(     )       |
| **Section 2. Treatment Summary** |
| OCR PROGRAM END DATE      | OCR PROGRAM END LOCATION      |
| DIAGNOSIS(ES) AT PROGRAM END      |
| MEDICATIONS AT PROGRAM END      |
| REASON FOR DISCHARGE[ ]  Charges dismissed [ ]  Found not competent [ ]  Found competent[ ]  Found not restorable [ ]  Return to jail [ ]  Revoked conditions of release[ ]  Inpatient medical care [ ]  Inpatient civil psychiatric care [ ]  Death[ ]  Other:       |
| **Progress toward Barriers to Competency (list barriers and interventions / progress)** |
|       |
| **Summary of Overall Program Participation** |
|       |
| **Section 3. Follow Up Care** |
| **Outpatient Behavioral Health Services** |
| DATE / TIME OF NEXT APPOINTMENT      | IF NO APPOINTMENT, WHY?      |
| STREET ADDRESS CITY STATE ZIP CODE                     |
| COMMENTS      |
| **Substance Use Disorder Services** |
| DATE / TIME OF NEXT APPOINTMENT      | IF NO APPOINTMENT, WHY?      |
| STREET ADDRESS OF APPOINTMENT CITY STATE ZIP CODE                     |
| COMMENTS      |
| **Other Appointment (medical, legal, vocational, educational, day program, language, etc.)** |
| PROVIDER AND CONTACT PERSON      | PHONE NUMBER (WITH AREA CODE)(     )       |
| EMAIL ADDRESS      |
| TYPE OF SERVICE      |
| DATE / TIME OF NEXT APPOINTMENT      | IF NO APPOINTMENT, WHY?      |
| STREET ADDRESS OF APPOINTMENT CITY STATE ZIP CODE                     |
| COMMENTS      |
| **Other Appointment (medical, legal, vocational, educational, day program, language, etc.)** |
| PROVIDER AND CONTACT PERSON      | PHONE NUMBER (WITH AREA CODE)**(     )** |
| EMAIL ADDRESS      |
| TYPE OF SERVICE      |
| DATE / TIME OF NEXT APPOINTMENT      | IF NO APPOINTMENT, WHY?      |
| STREET ADDRESS OF APPOINTMENT CITY STATE ZIP CODE                     |
| COMMENTS      |
|  |
| PERSON COMPLETING FORM      | DATE FORM COMPLETED      |