OKLAHOMA DEPARTMENT OF CORRECTIONS

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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
_____	_____	_____	_____
_____	_____	_____	_____

OKLAHOMA DEPARTMENT OF CORRECTIONS
INVOLUNTARY MEDICATION REPORT

(To be completed by Psychiatrist)

Inmate Name: _____ O**DOC 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