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. Investigation

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
[ ] Yes [ ] No

B. The inmate's DSM diagnosis
[ ] Yes [ ] No

C. The inmate's individualized treatment plan
[ ] Yes [ ] No

D. The medication and dosage prescribed for the inmate by the treating psychiatrist
[ ] Yes [ ] No

E. Signs, symptoms, and behaviors observed by mental health staff indicating that one or more of the follow apply: (*check each that apply*):

[ ] There is a substantial likelihood of serious physical harm to self.

[ ] There is a substantial likelihood of serious physical harm to others.

[ ] There is a substantial risk of significant property damage that may result in harm to self/others.

[ ] The inmate is gravely disabled and is unable to care for himself/herself so that his/her health and safety is endangered.

[ ] The inmate is gravely disabled and is incapable of participating in any treatment plan that would offer the inmate a realistic opportunity to improve his/her condition and alleviate physical suffering and/or further deterioration.

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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/herself.

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 himself/herself so that his/her 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 his/her 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
Psychiatrist/Physician	☐	☐	
CHSA/Designee	☐	☐	
Administrative/Security Representative	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	

Medication Review Committee Chairperson (Psychologist) _____ Date _____

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 must 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: _____, Warden, _____ date.

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

Printed Name	Signature	Position

Date: _____ Time: _____

cc: Warden
Inmate
Medical File
Chairperson
Psychiatrist

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