

CONDITIONAL RELEASE FOLLOW-UP REPORT

This follow-up report is to be completed by Forensic Monitors on discharged NGRI and IST-U-CJ patients and submitted to Legal Assurance Administrators. Report is due 30 days following discharge of patient from a Behavioral Healthcare Organization (BHO).

Today's Date	Date of Discharge	Date of Last Contact with Patient by Monitor or Treating Agency
Name of Patient		Patient No. (MACSIS UCI)
Name of BHO		Name of Monitor
Living Arrangements <input type="checkbox"/> Group Home <input type="checkbox"/> Individual Home <input type="checkbox"/> Shelter <input type="checkbox"/> Supervised Apartment <input type="checkbox"/> Other (specify) _____		
Employment/Training Program (specify where, what job) <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> None 		
Financial Support Type <input type="checkbox"/> Family Support <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Other Retirement <input type="checkbox"/> Salary or Earned Income <input type="checkbox"/> Soc. Sec. Retirement <input type="checkbox"/> SSDI <input type="checkbox"/> SSI <input type="checkbox"/> Veterans <input type="checkbox"/> Worker's Comp <input type="checkbox"/> Other (specify) _____		
Did the person keep the first scheduled appointment at agency? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Appointment	Rescheduled Date
If not, why?		
Agency Name		
Compliance with CR Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have there been any violations of the conditional release plan requiring court notification since discharge? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, type of violation? <input type="checkbox"/> Medication Noncompliance <input type="checkbox"/> Substance Abuse/Usage <input type="checkbox"/> Treatment Appointments, No Show <input type="checkbox"/> Other Violations (specify) _____		
Other Problems Noted <input type="checkbox"/> Health Concerns <input type="checkbox"/> Homelessness <input type="checkbox"/> No Socialization <input type="checkbox"/> Other (specify) _____		
Provide Feedback to the BHO Regarding Discharge <input type="checkbox"/> Was the hospital risk assessment received? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Was the patient ready to leave BHO at time of discharge? (belongings packed, received 2 weeks supply of medications, clinically cleared, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No If no, Describe Problem _____ _____ _____ <input type="checkbox"/> Other Feedback Regarding this Patient (specify) _____ _____		