

**OKLAHOMA DEPARTMENT OF CORRECTIONS**

\_\_\_\_\_  
Correctional Center

**Medication Review Committee Report**

Inmate Name: \_\_\_\_\_ DOC Number: \_\_\_\_\_ Location: \_\_\_\_\_

In accordance with the Department of Corrections Operations Memorandum OP-140652 entitled "Involuntary Administration of Psychotropic Medication in Non-Emergency Medical 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-patient's medical file.

- A. The results of a psychiatric examination reflecting the inmate-patient's mental status  
[ ] Yes [ ] No
- B. The inmate-patient's DSM-IV diagnosis  
[ ] Yes [ ] No
- C. The inmate-patient's individualized treatment plan.  
[ ] Yes [ ] No
- D. The medication and dosage prescribed for the inmate-patient 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 the inmate-patient or to others.
  - [ ] There is a substantial likelihood of significant property damage.
  - [ ] The inmate-patient is gravely disabled and is unable to care for himself/herself so that his/her health and safety is endangered.
  - [ ] The inmate/patient is gravely disabled and is incapable of participating in any treatment plan that would offer the inmate/patient a realistic opportunity to improve his/her condition and alleviate physical suffering and/or further deterioration.

Inmate Name: \_\_\_\_\_ DOC Number: \_\_\_\_\_

II. Record of the hearing

A. Date of hearing: \_\_\_\_\_ Time of hearing: \_\_\_\_\_ A.M. / P.M.

B. Inmate-patient [ ] **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-patient (if no cross-examination was not permitted or was limited, state reason(s): \_\_\_\_\_

\_\_\_\_\_

E. Statement by the inmate-patient and/or staff representative (list on separate page if necessary): \_\_\_\_\_

\_\_\_\_\_

F. Evidence presented by the inmate-patient. Attach additional pages if necessary. (If the inmate-patient 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: \_\_\_\_\_ DOC Number: \_\_\_\_\_

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-patient's mental health is likely, thus presenting a substantial risk of imminent harm to himself/herself or others.
- B.  Without medications, continued decompensation of the inmate-patient's mental health is likely, thus presenting a substantial likelihood the inmate-patient will cause significant property damage.
- C.  Without medications, continued decompensation of the inmate-patient's mental health is likely, thus presenting a substantial likelihood that the inmate-patient will be unable to care for himself/herself so that his/her health and/or safety is endangered.
- D.  Without medications, continued decompensation of the inmate-patient's mental health is likely, thus presenting a substantial likelihood that the inmate-patient would be incapable of participating in any treatment plan which would offer the inmate-patient 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:

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THEREFORE, pursuant to and in accordance with the Department of Corrections OP-140652 entitled "Involuntary Psychotropic Medication in Non-Emergency Medical 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: \_\_\_\_\_ DOC Number: \_\_\_\_\_

Medication Review Committee Signature	Approve	Disapproved	Date
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

\_\_\_\_\_  
 Medication Review Committee Chairman

\_\_\_\_\_  
 Date

2. The Committee does not adopt the recommendation that \_\_\_\_\_,  
 DOC Number \_\_\_\_\_, receive involuntarily administered medication.

\_\_\_\_\_  
 Medication Review Committee Chairman

\_\_\_\_\_  
 Date

Any appeal of this decision must be made in writing to the institution's physician or designee within 24 hours of the inmate's notification of the decision. The staff representative that assisted the inmate-patient at the Hearing will be available to assist in an appeal to the physician or designee.

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-patient within one working day of the warden's review by:

Printed Name	Signature	Position
_____	_____	_____

Date: \_\_\_\_\_ Time: \_\_\_\_\_

- cc: Warden  
 Inmate  
 Medical File  
 Psychologist  
 Psychiatrist

Inmate Name: \_\_\_\_\_ DOC Number: \_\_\_\_\_