

# OKLAHOMA DEPARTMENT OF CORRECTIONS

## Correctional Center

### INVOLUNTARY MEDICATION REPORT

(To be completed by Psychiatrist)

**Inmate Name:** \_\_\_\_\_ **DOC 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:** \_\_\_\_\_ **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 Warden's Office on date signed.

CC: Medical File.