MENTAL HEALTH SERVICES	**PSYCHIATRIC INVOLUNTARY ADMISSION REVIEW**

Facility:_____ Inmate Name: _____ TDCJ #: _____

Referring Psychiatrist/MLP:_____

Diagnosis: _____

Brief Case History:_____

_____

_____

_____

Date and Time of Hearing_____

Witnesses Present (include in whose behalf):_____

Clinical Director or Designee Findings and Disposition:_____

_____

_____

_____

_____Admit to behavioral health facility Comments:_____

or

_____Discharge to outpatient care Comments:_____

_____ _____

Signature of Clinical Director or Designee Date