I-70.2 Attachment B
Effective: 11/19/2018
Replaces: 1/8/2016
Reviewed: 10/2018

MENTAL HEALTH SERVICES	PSYCHIATRIC INVOLUNTARY ADMISSION REVIEW

Facility:_____ Offender 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

HSP-17 (Rev. 9/99)