416R

THE CITY OF NEW YORK
DEPARTMENT OF CORRECTION

DIRECTIVE

[ ] NEW	[ ] INTERIM	[X] REVISED	SUBJECT
EFFECTIVE DATE **02/19/14**	*TERMINATION DATE / /		**SUICIDE PREVENTION**

CLASSIFICATION #	SUPERSEDES	DATED	APPROVED FOR WEB POSTING	DISTRIBUTION	PAGE 1 OF 1 PAGES
4521	**See below**	**12/10/03**	[X] **YES** [ ] **NO**	**A**	

RECOMMENDED FOR APPROVAL BY REVIEW BOARD MEMBER	AUTHORIZED BY ACTING COMMISSIONER
EVELYN A. MIRABAL, CHIEF OF DEPARTMENT SIGNATURE	MARK CRANSTON SIGNATURE

REVISION NOTICE

A. Directive #4521, entitled SUICIDE PREVENTION, dated 12/10/03, is hereby amended as follows:

Remove original Form OD/HS 02 entitled "Mental Health Status Notification and Observation Transfer Form (TNF)" dated 12/10/03 and replace with new Form OD/HS 02 entitled "Mental Health Status Notification and Observation Transfer Form (TNF)" dated 02/2014.

B. All other provisions of Directive #4521 remain in full force and effect.

CORRECTION DEPARTMENT
CITY OF NEW YORK

FORM # OD/HS 02
REV 02 /14

REF: O/O # 22/93
DIR. 4521

MENTAL HEALTH STATUS NOTIFICATION AND OBSERVATION TRANSFER FORM (TNF)

TO BE COMPLETED BY MENTAL HEALTH / CLINICAL STAFF

INMATE NAME		FACILITY
BOOK & CASE #	NYSID #	DATE / /

BASED ON A CLINICAL INTERVIEW THIS DATE, THE FOLLOWING MARKED (X) INDICATIONS APPLY:

- ☐ SUICIDAL AND / OR HIGHLY SELF-INJURIOUS
- ☐ RECEIVING PSYCHOTROPIC MEDICATION
- ☐ 730 EXAMINATION PENDING
- ☐ HIGHLY ASSAULTIVE
- ☐ DEVELOPMENTALLY DISABLED
- ☐ HISTORY OF VIOLENCE TOWARDS _____

TRANSFER TO:

- PSYCHIATRIC PRISON WARD: ☐ BHPW ☐ EHPW
- DOC FACILITY: ☐ C-71 MENTAL HEALTH ☐ CAPS ☐ RHU ☐ PUNITIVE SEG
- OTHER M.O. HOUSING: ☐ DORMITORY ☐ CELL ☐ EITHER

SPECIAL PRECAUTIONS REQUIRED:

- ☐ CONSTANT SUICIDE WATCH
- ☐ GENERAL POPULATION - NO DANGER TO SELF OR OTHERS
- ☐ NO TRANSFER REQUIRED, BUT MOVE TO ☐ DORMITORY ☐ CELL

BASED ON MENTAL HEALTH STAFF REVIEW, THE INMATE:

- ☐ Has successfully completed all levels of the RHU program and is eligible for a fifty-percent punitive segregation time reduction incentive and abeyance.
- ☐ Has successfully completed the CAPS program and is eligible to have remaining punitive segregation time owed expunged.
- ☐ Has been evaluated and is clinically cleared for restoration of punitive segregation time held in abeyance.

ADDITIONAL INFORMATION / RECOMMENDATIONS:

MENTAL HEALTH STAFF SIGNATURE	TIME _____ HRS.
MENTAL HEALTH STAFF (PRINT)	DATE / /

TO BE COMPLETED BY DEPARTMENT OF CORRECTION STAFF

TIME OF NOTIFICATION TO DOC: _____ HRS.		PERSON NOTIFIED (PRINT NAME & RANK)	
TIME OF NOTIFICATION TO NAMCU: _____ HRS.		PERSON NOTIFIED (PRINT NAME & RANK)	
TRANSFER LOCATION	FACILITY	HOUSING AREA	BED / CELL
PERSON NOTIFIED AT RECEIVING LOCATION (AS REQUIRED)	PRINT NAME	RANK / TITLE	SHIELD NO. / I.D.