

**Department of Mental Health
Risk Review Summary (RRS)**

Date Assessment Completed:			
Name of Individual:	DOB:	Age:	Sex: Select One
Current location: Select One			
Area of Tie:	Site:		
Community Contact(s) Telephone/pager:			
Community Contact Email:			
Guardianship Status: Select One Select One Select One			
Name of Guardian or Legally Authorized Representative (LAR):			
Contact Information for Guardian/LAR:			

Brief Description of Items Screened Positive in CRIT	
Brief Description of Criminal and/or Juvenile Justice History:	
Number of Arrests:	Total Time Incarcerated and/or Committed to DYS:
Description of Prior Arrests and Legal Outcomes:	

Name/Contact information of Community Criminal/Juvenile Justice entity currently providing supervision (if applicable) (e.g., Probation, parole, DYS personnel):		
Review		
Reviewed by Supervisor	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Date:
Name of Supervisor:		
Reviewed by Site Director:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Date:
Recommendation for further Area Review	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Date:
Name of Site Director:		
Area Office Review (if Applicable)		
Reviewed by Area Medical Director/Senior Psychiatrist	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Date:
Name:		
Reviewed by Area Director/Director of Community Services	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Date:
Name:		
Comments, if any:		