PRISONER MEDICAL SCREENING

VISUAL OBSERVATIONS:

01. Is inmate conscious? .... Y: ✓ N: ____
02. Does inmate have obvious pain or bleeding or other symptoms suggesting need for emergency care? Y: ____ N: ✓
03. Are there visible signs of trauma or illness requiring immediate emergency or doctor's care? Y: ____ N: ✓
04. Is there obvious fever, jaundice or other signs of infection? Y: ____ N: ✓
05. Is the skin in good condition and free from rashes, lice and vermin? Y: ✓ N: ____
06. Does the inmate appear to be under the influence of alcohol and/or drugs? Y: ____ N: ✓
07. Are there any signs of drug and/or alcohol withdrawal? Y: ____ N: ✓
08. Does inmate display obvious signs of mental abnormalities? What? ____ Y: ____ N: ✓
09. Does inmate's behavior suggest the risk of suicide? Y: ____ N: ✓
10. Does inmate's behavior suggest the risk of assault to jail staff or other inmates? Y: ____ N: ✓
11. Does inmate appear to be mentally challenged or retarded? Y: ____ N: ✓
12. Are there noticeable or claimed body deformities, trauma markings, bruises, lesions or difficulty of movement? Y: ____ N: ✓
    If yes, describe: ____

INMATE QUESTIONNAIRE:

01. Are you presently on any medications? If yes, fill out "Medication Needed" below .... Y: ____ N: ✓
02. Do you have a history of Heart Disease, Seizures, Asthma, Arthritis, Jaundice, Ulcers, High Blood Pressure or Psychiatric Disorder? (Circle if applicable) ..... Y: ____ N: ✓
03. Are you on a special diet prescribed by a doctor? Y: ____ N: ✓
04. Do you have any other special health needs prescribed by a doctor? Y: ____ N: ✓ (if yes, describe in "Special Needs" below)
05. Do you have a history of Venereal Disease or abnormal discharge? Y: ____ N: ✓ (if yes, describe in "Special Needs" below)
06. Have you recently been hospitalized within the last six months? Y: ____ N: ✓
07. Are you allergic to any medications: Y: ____ N: ✓ (if yes, what?: ____)
08. Have you fainted lately or received any head injuries? Y: ____ N: ✓
09. Do you have a history of epilepsy, tuberculosis, diabetes or mental illness? (Circle if applicable) Y: ____ N: ✓
10. Have you ever had Hepatitis? Y: ____ N: ✓
11. If female, are you pregnant or do you have any health problems specific to women? Y: ____ N: ✓
12. Do you have any medical problems not yet mentioned? Y: ____ N: ✓ (if yes, what? ____)
13. Do you have any painful dental problems? Y: ____ N: ✓
14. Do you use alcohol? Y: ✓ N: ____ If so, how often? ____
15. Do you use any type of drugs? Y: ____ N: ✓ If so, what type? ____ How much? ____
    When did you use drugs last? ____ How often? ____
16. Have you ever been in a residential treatment center for Alcoholism, Drug Abuse, Other Addiction? ____ Do you "mainline" drugs? Y: ____ N: ____
    (If yes, circle applicable) Where: ____ Y: ____ N: ✓
17. Have you ever been a patient in a mental hospital/facility? Y: ____ N: ✓ When? ____ Where? ____
    When? ____
18. Who is your personal physician? Dr: ____ Phone: ____
19. Do you have any intention of hurting yourself or committing suicide? Y: ✓ N: ____

Screening Officer's Initials: MAL

Inmate's Initials: [illegible]

ASSESSMENT/DISPOSITION

If Visual Observation Numbers 1 or 5 was answered NO, or any other Observation or Question was answered YES:

01. Was emergency treatment required and provided before incarceration? Y: ____ N: ____
    Where? ____ By Whom: ____ Date/Time: ____
02. Are non-emergency medical needs documented in "Special Needs" below? Y: ____ N: ____

If there are any indications of a suicide risk:

01. Was hospitalization attempted? Y: ____ N: ____ Where: ____ When: ____
    Was the inmate accepted: ____ rejected: ____ for hospitalization after assessment?
02. Was a 20 Minute Watch implemented and documented in Special Needs Section? Y: ____ N: ____
03. Was a Mental Health Specialist contacted for assessment? Y: ____ N: ____ When? ____

MEDICATION/TREATMENT

Is medication needed? Y: ____ N: ____ (Prescription: ____ Other: ____) Projected Length of Stay: ____

1. Medication ____ By Doctor ____ Amount/Stay ____
   Confirmed by ____ Ordered by ____ Picked up by ____ Date/Time ____
2. Medication ____ By Doctor ____ Amount/Stay ____
   Confirmed by ____ Ordered by ____ Picked up by ____ Date/Time ____
3. Medication ____ By Doctor ____ Amount/Stay ____
   Confirmed by ____ Ordered by ____ Picked up by ____ Date/Time ____
4. Medication ____ By Doctor ____ Amount/Stay ____
   Confirmed by ____ Ordered by ____ Picked up by ____ Date/Time ____

PRISONER TREATMENT ...