INTRA-SYSTEM TRANSFER HEALTH SCREENING

Health/Mental Health trained staff will complete the health screening immediately upon the inmate's arrival at the receiving institution. Route to the health service unit within 24 hours of the inmate's reception for review and inclusion into medical record. **Refer to Mental Health if "YES" to any mental health question and/or medications including abuse and/or sexually aggressive behavior.**

1. Do you have hearing or vision problem? YES NO
2. Are you currently being treated for any medical, mental, or dental problems? YES NO
   (Infectious disease, STD, Chronic, etc.)
3. Are you currently taking any medications? (If "Yes", health reason, i.e. blood pressure, psychotropic, etc.) YES NO
   _____

   Check One: ☐ Medication in Inmate Property ☐ Medication with Health Record ☐ No Medication Received
   If medication received, list medication:
4. Do you have any medical, mental, or dental problems other than the above mentioned? YES NO
5. Do you require assistance to stand or walk? YES NO
6. Have you ever attempted or had thoughts of suicide? YES NO
7. Have you ever had psychiatric treatment inpatient or outpatient? YES NO
8. Do you have history of substance abuse? YES NO
   If "Yes": alcohol or drug type, mode of use, amount used, frequency and date/time of last use included on "Medical/Mental Health Screening (DOC 140114A)
9. Have you ever been a victim of abuse? (mental health) YES NO
   If "Yes" check all that apply: ☐ Sexual ☐ Physical ☐ Mental
10. Have you ever had a potential for violence? YES NO
    Would you like a referral to a Qualified Mental Health Professional? YES NO
11. Have you ever had a potential for sexually aggressive behavior? YES NO
    Would you like a referral to a Qualified Mental Health Professional? YES NO
12. Does the inmate have any visual evidence of physical abuse, bruises, lesions, rashes, jaundice, infestation, physical deformities, trauma and/or needle marks or other indications of drug abuse? YES NO

    Comment: _____
13. General appearance and behavior

    ☐ Good ☐ Sweating ☐ Tremors ☐ Anxious ☐ Nervous ☐ Consciousness ☐ Conduct ☐ Other: _____

    Comment: _____

MENTAL STATUS: (Check appropriate status)

- ☐ Inmate can state name, place, and time
- ☐ Inmate cannot state name, place, and time
- ☐ Inmate shows symptoms of psychosis, depression, anxiety and/or aggression

DISPOSITION: (Check as appropriate)

- ☐ To General Population (no referral to health/mental health services)
- ☐ To General Population (with referral to health/mental health services)
- ☐ To Special Housing
- ☐ To Health/Mental Health Services

VERBAL AND WRITTEN ORIENTATION SHEET GIVEN TO INMATE (5-ACI-6A-01M) **Inmate's initials: ___** YES NO

IN CASE OF EMERGENCY NOTIFY:

Name: _____Relationship: _____

Address: _____Phone: (_____)_____

Screener's Name/Title: _____ Date: _____Time: _____

Reviewed By: _____ Date: _____Time: _____
(Qualified Healthcare Professional Signature/Title-ensure this is legible)

Transferring Facility: _____ Receiving Facility: _____

Inmate's Name: (Last, First) ODOC #: