

# OKLAHOMA DEPARTMENT OF CORRECTIONS

## Individual Health Activity Profile (IHAP)

### HOUSING ASSIGNMENT RECOMMENDATIONS (Justification for special assignments must be documented by medical necessity.)

#### Basic Housing (check all that apply)

- ☐ No restrictions
- ☐ Requires facility with 24/7 medical staff
- ☐ Requires infirmary care
- ☐ No Halfway House - **BRITTLE INSULIN DEPENDENT DIABETICS ARE RESTRICTED**
- ☐ No county jail placement
- ☐ No private prisons
- ☐ No IDDM at NFCC, OSR Minimum/Medium, ECCC, LCCC
- ☐ Restricted to current facility with the exception of Global Position Satellite Surveillance (GPS) Program
- ☐ Requires daily medical supervised pill line
- ☐ Requires on-site medical care - **INSTITUTION AND COMMUNITY ONLY**
- ☐ Pregnant

#### Bunk Assignment

- ☐ No restrictions
- ☐ Lower bunk

#### Quad Assignment

- ☐ No restrictions
- ☐ Lower rung
- ☐ Handicap accommodations

### PHYSICAL CAPABILITY (All sections scored over 1 require explanation on PE or progress note)

UPPER EXTREMITIES	Score	LOWER EXTREMITIES	Score	Eyes	Score
Normal	1	Normal	1	Normal	0
Mild functional loss	2	Mild functional loss	2	≤ 20/40 with or without	1
Moderate functional loss	3	Moderate functional loss	3	Legally blind	4
Severe restriction	4	Severe restriction	4	<b>SCORE</b>	
<b>SCORE</b>		<b>SCORE</b>			

HEARING	Score	ACTIVITY	Score
Normal	0	Unrestricted activity	0
Mild loss of hearing	1	Mild restrictions	1
Moderate loss of hearing	2	Moderate limits	2
Severe loss of hearing	2	Severe limits	3
Deaf	2	Medically unassigned	4
Y Read Lips		<b>SCORE</b>	
Y Signs			
Y Written Communication			
<b>SCORE</b>			

GRADE: W \_\_\_\_\_ (HIGHEST NUMBER FROM SCORING)

IHAP Codes: MA \_\_\_\_\_ W \_\_\_\_\_ MH \_\_\_\_\_ O \_\_\_\_\_

Based upon medical examination and/or review the inmate is cleared and approved to work in food service:

- ☐ Yes
- ☐ No

### ACTIVITY RESTRICTIONS (Check all that apply)

Based upon medical examination and/or review the following restrictions apply. Inmates may not remove themselves from these medical restrictions without clinical documentation.

- ☐ No restriction
- ☐ Psychiatrically unassigned
- ☐ Sedentary work only
- ☐ No walking more than \_\_\_\_\_ yards
- ☐ No lifting over \_\_\_\_\_ pounds
- ☐ No walking on wet or uneven surfaces
- ☐ No prolonged sitting or standing
- ☐ No reaching over shoulder
- ☐ Other restrictions (list) \_\_\_\_\_
- ☐ No frequent bending or stooping
- ☐ No prolonged sun exposure or direct sunlight
- ☐ No work requiring safety boots
- ☐ No excess heat, humidity, or cold exposure
- ☐ No operating machinery
- ☐ No climbing ladders
- ☐ No repetitive use of hands
- ☐ No outside work crew

Facility Name \_\_\_\_\_ Review Date \_\_\_\_\_ Healthcare Provider/RN/LPN \_\_\_\_\_

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Facility Name \_\_\_\_\_ Review Date \_\_\_\_\_ Healthcare Provider/RN/LPN \_\_\_\_\_

**IF THE INMATE'S MEDICAL STATUS HAS CHANGED A NEW HOUSING SUMMARY MUST BE COMPLETED.**

Inmate Name  
(Last, First)

ODOC Number