OKLAHOMA DEPARTMENT OF CORRECTIONS

MEDICAL TRANSFER REQUEST

Move Request: ❑ Medical Move

Date: _____ Time: _____

Requesting Facility: Requesting CHSA/Provider: _____

Inmate Name: _____ ODOC #: _____

DOB: _____ Gender: ❑ M ❑ F

Security Level: ❑ Halfway House ❑ Community ❑ Minimum ❑ Medium ❑ Maximum

Current Individual Health Activity Profile (IHAP) completed ❑ Yes ❑ No (IHAP must accompany all "Medical Transfer Requests")

IHAP Group Codes: MA_____ W_____ MH_____ O_____

Primary Diagnosis: _____

Severity Classification: ❑ Mild ❑ Moderate ❑ Severe

Secondary Diagnosis: _____

Severity Classification: ❑ Mild ❑ Moderate ❑ Severe

Clinical Justification for Transfer: _____

_____

_____

_____

_____

Requires Lower Bunk: ❑ Yes ❑ No Requires Lower Rung/Level: ❑ Yes ❑ No Requires Handicap accommodations: ❑ Yes ❑ No

Is inmate currently in hospital: ❑ Yes ❑ No If "Yes" where: _____

Palliative Care Eligible: ❑ Yes ❑ No DNR signed: ❑ Yes ❑ No Comments: _____

Emergency transfer: ❑ Yes ❑ No If "Yes" state reason: _____

_____

Can inmate be transported by Central Transport Unit: ❑ Yes ❑ No **Note:** If inmate is wheelchair bound, located at a hospital or if move is needed same day as request the inmate cannot be transported by CTU.

* Fax completed "Medical Move Request" to **405-425-2911**.
* If medical move has not occurred within two weeks contact Health Services.

To be filled out by Medical Services Central Office:

Received by: _____ Date: _____

Medical transfer approved: ❑ Yes ❑ No If "No" state reason: _____

_____

Comments:

_____

_____

Facility transferred to: _____ Date faxed to receiving provider: _____