OKLAHOMA DEPARTMENT OF CORRECTIONS
MEDICAL/MENTAL HEALTH SCREENING (5-ACI-6A-32M b#1, b#3)

INMATE NAME: _____ ODOC#: _____
DOB: _____/_____/_____ ☐ Male ☐ Female COUNTY FROM: _____
SCREENED BY: _____ DATE: _____/_____/_____ TIME: _____ ☐ AM ☐ PM

I. CONTACT FOR EMERGENCY:

Name: _____ Home Phone: _____ Work Phone: _____
Name: _____ Home Phone: _____ Work Phone: _____

II. MEDICAL/PHYSICAL

A. Are you currently taking any medications? ☐ YES ☐ NO

Name of medications:

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

B. Are you aware of any medication allergies? ☐ YES ☐ NO

Name of medications:

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

C. Have you ever been or are you currently being treated for (check all that apply): (5-ACI-6A-21M b#2, b#5)

	Current Symptoms	Personal History	Family History	Comments
Childhood Diseases (Chickenpox, Measles, Mumps)				
Heart Disease or Chest Pain				
Respiratory Problems				
Neurological Problems (Seizures, Parkinson, Huntington's, MS)				
Urinary Problems (Renal stones, Hematuria, Dysuria)				
Sexually Transmitted Disease				
Cancer				
Diabetes				
Hepatitis (A, B, C)				
Hypertension				
Tuberculosis				
Pregnancy				
Female problems that required medical or surgical treatment				
Stomach Disease (Hematemesis, Ulcers, Melena)				
Disease of Blood (Sickle cell, Hemophilia etc.)				
Muscle/Skeletal Problems (Arthritis, Bone and Joint, Deformities)				
Dermatological Problems (Sores, Rashes, Acne, etc.)				
Other (explain):				

D. Do you have any of the following? (Check all that apply)
❑ Ostomy ❑ Eye glasses/Contact lens ❑ Hearing aids ❑ False teeth
❑ Artificial Limbs Where: _____

E. Have you ever been hospitalized? (List reason) _____

F. Have you ever had surgery? (List reason) _____

III. DENTAL (5-ACI-6A-21M b#3, 5-ACI-6A-25M b#5, b#10)

1. Are you currently being treated for dental problems? ☐ YES ☐ NO
   If "Yes" explain: _____

IV. LIVING WILL/ADVANCED DIRECTIVES

1. Do you currently have a Living Will/Advanced Directive? YES / NO
   Inmate Name: _____ ODOC #: _____

V. MENTAL HEALTH (5-ACI-6A-25M b#4, b#10)

1. Educational History. Last grade attended (5-ACI-6A-32M b#2d) _____
2. Have you ever been hospitalized or treated for mental or emotional problems? YES / NO (5-ACI-6A-31M b#, b#5, b#6, 5-ACI-6A-32M b#2, b#2a, b#2b.)
3. Have you ever attended psychotherapy, psycho-educational groups, and/or support groups? YES /NO (5-ACI-6A-32M b#2.c.)
4. Have you ever been prescribed any psychiatric drugs? YES / NO (5-ACI-6A-31M b#3, 5-ACI-6A-32M b#2b)
   Name of medications:
   _____ _____
   _____ _____
5. Have you ever-attempted suicide, or had thoughts of suicide? YES / NO (5-ACI-6A-32M b#3a; 5-ACI-6A-31M b#2)
6. Are you currently having thoughts of suicide? YES / NO (5-ACI-6A-31M b#1, 5-ACI-6A-32M b#3a)
7. Have you ever had a potential for violence or sexually aggressive behavior? YES / NO (5-ACI-6A-32M b#3b, 5-ACI-3D-10)
8. Have you ever been a victim of abuse? YES / NO (check all that apply) ☐ Sexual ☐ Physical ☐ Mental (5-ACI-6A-32M b#2f)
9. Would you like a referral to a qualified mental health professional regarding the abuse and/or behavior? (5-ACI-6A-32M b# 3f) YES / NO

VI. ALCOHOL/DRUGS/TOBACCO (5-ACI-6A-32M b#2e, 3c.)

1. Have you ever used or been treated for alcohol or drugs? YES / NO (5-ACI-6A-21M b#4, 5-ACI-6A-31M b#7, 5-ACI-6A-32M b#2e, b#3c; 4-ACRS-4C-06 b#4) If "Yes" include; date last used, mode of use, amount used, frequency, any problems occurring after ceasing use.

Drug	Date last used	Mode of use	Amount used	Frequency	Problems after ceasing use

2. Have you ever had DTs or convulsions after ceasing use? YES / NO (5-ACI-6A-21M b#4)
3. Do you smoke? YES / NO If yes how many packs a day: _____ How many years? _____

VII. INMATE Observation (5-ACI-6A-31M b#8, b#9, b#10)

1. Behavior, including state of consciousness, mental status, appearance, conduct, tremor or sweating. (5-ACI-6A-21M b#7, 5-ACI-6A-31M b#9, b#10)
2. Body deformities, ease of movement, etc. (5-ACI-6A-21M b#7)
3. Condition of skin, including trauma markings, bruises, lesions, jaundice, rashes, infections, infestations, surgical scars, tattoos and needle marks or other indications of drug use. (5-ACI-6A-21M b#9, 5-ACI-6A-31M b#11)

   Comments: _____

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VIII. DISPOSITION (Circle all that apply) (5-ACI-6A-21M, 5-ACI-6A-31)

1. To assessment and reception housing unit: (5-ACI-6A-21M b#10, 5-ACI-6A-31M #13)

2. To assessment and reception housing unit with prompt referral to the health services unit: (5-ACI-6A-21M b#11, 5-ACI-6A-31M b#14, 50ACI-6A-32M b#3e)

   ❑ Medical Provider ❑ Psychiatrist ❑ Qualified Mental Health Professional ❑ Dentist ❑ Case Manager

   Specify Reason:

   _____

3. Immediate referral for emergency services: (5-ACI-6A-21M b#12, 5-ACI-6A-31M b#15)

   ❑ Medical Provider ❑ Psychiatrist ❑ Qualified Mental Health Professional ❑ Dentist ❑ Case Manager

   Specify Reason:

   _____

   QHCP SIGNATURE:

   _____