

OKLAHOMA DEPARTMENT OF CORRECTIONS
REQUEST FOR HEALTH SERVICES

TO BE COMPLETED BY INMATE

Facility: _____ Date: _____

Inmate Name _____ ODOC # _____ Unit _____

I request the following service(s): (Check appropriate box(s))

☐ Medical ☐ Mental Health ☐ Dental ☐ Optometry (eye) ☐ Medication Renewal
(expired medications only)

Reason for service: _____

I understand that in accordance with operations memorandum OP-140117 entitled, "Access to Health Care", I will be charged \$4.00 for each medical service I request and a charge of \$4.00 for each medication(s) dispensed to me, with the exceptions noted in the above-reference operations memorandum. There is no charge to the offender for mental health services and/or mental health medications.

Inmate Signature _____ Date: _____

TO BE COMPLETED BY HEALTH SERVICES

Date Received

Initials

Comment: _____

RN/LPN/Health Care Provider Signature

Date

"Return the "Request for Health Services" (DOC 140117A) with the disposition of the inmate's request in the comment section to the inmate after scanning into the inmate's EHR.

NOTE: All "Keep on Person" (KOP's) medication refill requests must be submitted to the facility's health services unit or to the medical host facility, using the "Medication Refill Slip" (DOC 140130M). "Medication Refill Slips" must be submitted within ten days of the date the medication expires or runs out. "Medication Refill Slips" are readily available and accessible at designated locations within the facility.

DOC 140117A
(R 12/21)