APPENDIX -A

Institution _____ DOB _____

RESIDENT NAME _____ NO. _____

EDICAL REPORT

1. General Medical Status: Satisfactory ☐ Unsatisfactory ☐
2. Acute Primary Problem(s): _____
3. Treatment Plan: _____
4. Drug Sensitivity or Allergies: _____
5. Present Medication (Dosage): _____
6. History of Drug Abuse: Yes ☐ No ☐ Alcohol Abuse: Yes ☐ No ☐
7. Presently Under Psychiatric Care of (Name of Psychiatrist) _____
8. Date of Last Physical Exam: _____
9. Medical Summary: _____
10. Approved for Transfer: Yes ☐ No ☐

Attending Physician _____ Date _____

DENTAL RECORD

11. General Dental Status: Satisfactory ☐ Unsatisfactory ☐
12. Acute Problem(s): _____
13. Treatment Plan: _____
14. Date of Last Dental Exam: _____
15. Dental Summary: _____
16. Approved for Transfer: Yes ☐ No ☐

Attending Dentist _____ Date _____

USE OTHER SIDE FOR ADDITIONAL SUMMARY INFORMATION

APPENDIX B

# MEDICAL ENTRANCE SCREEN

Inmate's Name _____ D.O.B. _____ Receiving Institution _____

Interviewer _____ Date _____ Sending Institution _____

Title _____ Time _____ A.M. / P.M.

PART I VISUAL OBSERVATION (Check yes or no; where answer is yes, note remarks.)

| | | YES | NO | REMARKS |
|---|---|---|---|---|
| 1. | Is the inmate conscious? | | | |
| 2. | Are there any signs of recent trauma? (lacerations, contusions, open wounds, etc.) | | | |
| 3. | Are there any visible signs of acute illness? | | | |
| 4. | Are there any visible skin problems? (ulcers, abscesses, infestations, rashes, jaundice) | | | |
| 5. | Are there any visible signs of alcohol and/or chemical influence? | | | |
| 6. | Are there any visible signs of alcohol/drug withdrawal symptoms? | | | |
| 7. | Are there any indications of depression and/or disorientation? (neurotic or psychotic) | | | |
| 8. | Are there any gross signs of suicidal behavior? | | | |
| 9. | Are there any visible body deformities or restricted movement? | | | |

Vital Signs:

| | | NORMAL |
|---|---|---|
| Temperature | _____ | (98.6) |
| Blood Pressure | _____ | (120/80) |
| Pulse | _____ | (80) |
| Respiration (optional) | _____ | (18) |

Date of last physical examination _____

Date of last dental examination _____

***(SEE OTHER SIDE)

PART II MEDICAL INQUIRY

| | YES | NO | REMARKS |
|---|---|---|---|
| 1. Are you currently taking any medication? If yes, for what condition(s)? | | | |
| 2. Are you allergic to any medications?(If yes, list) | | | |
| 3. Do you have a special diet prescribed by a physician? (If yes , list type of diet.) | | | |
| 4. Have you had venereal disease? | | | |
| 5. Do you have any abnormal discharge at this time? | | | |
| 6. Have you had tuberculosis? | | | |
| 7. Have you had hepatitis? | | | |
| 8. Do you have epilepsy? | | | |
| 9. Have you fainted recently or had a head injury? | | | |
| 10. Do you have frequent headaches? | | | |
| 11. Do you have a painful dental condition? | | | |
| 12. (If female) Are you pregnant? | | | |
| 13. (If female) Have you recently delivered? | | | |
| 14. Do you have a history of drug or alcohol abuse? (If yes, not the drug, mode of use, amount/ frequency used, any problems with cessation) | | | |
| 15. Have you ever been treated for a mental illness? | | | |
| 16. Do you have any other medical problems not mentioned? | | | |

PART III DISPOSITION (check one)

1. _____ To General Population. 2. _____ To General Population with referral to

APPENDIX C

Name & Number _____

Date: _____

Medical Confidential

# Health History

| HAVE YOU EVER? | YES | NO |
|---|---|---|
| Lived with anyone who had TB | | |
| Coughed up blood | | |
| Bled excessively after injury | | |
| Attempted suicide | | |

| HAVE YOU EVER HAD OR HAVE YOU NOW? | YES | NO | DON'T KNOW |
|---|---|---|---|
| Asthma | | | |
| Tuberculosis | | | |
| Cancer or Tumor | | | |
| Diabetes | | | |
| Emphysema | | | |
| Ear, Nose, or Throat Trouble | | | |
| Hearing Loss | | | |
| Chronic or Frequent Colds | | | |
| Hay Fever | | | |
| Severe Tooth or Gum Trouble | | | |
| Shortness of Breath | | | |
| High Blood Pressure | | | |
| Pain or Pressure in Heart | | | |
| Pounding Heart | | | |
| Arthritis or Bursitis | | | |
| Fractures (Broken Bones) | | | |
| Bone, Joint, or Other Deformity | | | |
| Painful or Trick Shoulder | | | |
| Foot Trouble | | | |
| Recurrent Back Trouble | | | |
| Swollen or Painful Joints | | | |
| Kidney Trouble | | | |
| Frequent or Painful Urination | | | |
| Blood in Urine | | | |
| Recurrent Infections | | | |
| Rheumatic Fever | | | |

YOUR PRESENT DOCTOR'S NAME (Address, Phone)

Have you ever been treated for a mental condition? (If yes, state reason and give details)

Highest level of education (years)

Have you ever been incarcerated in this jail before? (if so, when?)

| DO YOU? | YES | NO |
|---|---|---|
| Wear glasses or contact lenses | | |
| Have vision in both eyes | | |
| Wear a brace or back support | | |

| HAVE YOU EVER HAD OR HAVE YOU NOW? | YES | NO | DON'T KNOW |
|---|---|---|---|
| Night Sweats | | | |
| Tumors, Cysts, or Growths | | | |
| Cramps in your Legs | | | |
| Rupture or Hernia | | | |
| Recent gain or loss of Weight | | | |
| Frequent Indigestion | | | |
| Stomach Trouble or Ulcer | | | |
| Hepatitis or Jaundice | | | |
| Gall Bladder Trouble | | | |
| Hemorrhoids or Rectal Trouble | | | |
| Head Injuries | | | |
| Epilepsy or Seizures | | | |
| Frequent or Severe Headaches | | | |
| Loss of Memory or Amnesia | | | |
| Periods of Unconsciousness | | | |
| Paralysis, Numbness, Weakness | | | |
| Dizziness, Fainting Spells | | | |
| Nervous Problem of Any Type | | | |
| Alcoholism | | | |
| Syphilis, Gonorrhea | | | |
| Drug Allergies | | | |
| Lumps, Pain, Discharge on Breast | | | |
| Change in Menstrual Pattern | | | |
| Pregnancy/Abortion/Miscarriage | | | |
| Treated for Female Disorder | | | |
| Thyroid Trouble | | | |

Have you ever been a patient or received treatment in a hospital? (surgery/injuries); state where, when, why & address

Have you ever taken narcotics? (If yes, state what kind, when you last took it, and if you are in a treatment program)

Additional Remarks: (use reverse side)

APPENDIX D

Medical Confidential

# Physical Examination

Name & Number _____

Date: _____

| Blood Pressure: | Pulse Rate: | | |
|---|---|---|---|
| Height: | Weight: | Temp: | Visual Acuity: |

General appearance: ☐ Healthy ☐ Unhealthy

| PARTS OF THE BODY | | OBSERVATION |
|---|---|---|
| 1. Head, face, scalp | | |
| 2. Skin | (a) lesions, ulcers, jaundice | |
| | (b) lacerations, tracks | |
| 3. Eyes | (a) pupils | |
| | (b) conjunctiva, sclera | |
| 4. Ears | (a) pinnae, canals, drums | |
| | (b) gross hearing | |
| 5. Nose | | |
| 6. Mouth | (a) teeth/dentures | |
| | (b) throat | |
| 7. Neck | (a) lymph nodes | |
| | (b) masses | |
| 8. Chest Wall | | |
| 9. Breasts | | |
| 10. Lungs | | |
| 11. Heart | (a) rate | |
| | (b) murmurs | |
| 12. Abdomen (appearance) | | |
| 13. Liver | (a) size (cm) | |
| | (b) tenderness | |
| | (c) edge | |
| 14. Spleen | | |
| 15. Groin | (a) nodes | |
| | (b) lesions | |
| | (c) hernias | |
| 16. Back | (a) pain | |
| | (b) range of motion | |
| 17. Extremities | (a) clubbing | |
| | (b) tracks | |
| 18. Flanks | | |
| 19. Joints | (a) deformity | |
| | (b) range of motion | |
| 20. Neurologic | (a) reflexes | |
| | (b) gross touch | |
| | (c) gait | |
| | (d) oriented | |
| | (e) speech | |
| 21. Rectal | | |
| 22. MALES: Penis, scrotum, testes | | |
| 23. FEMALES: | (a) vulva, vagina | |
| | (b) cervix | |
| | (c) uterus, adnexae | |

Laboratory Results: RPR or VDRL

Mantoux _____ MM

**Disposition/Referral**

_____

Signature of Examiner

APPENDIX E

NAME: Last_____ First_____ Middle_____ 2. DATE OF EXAM:

| 3. INSTITUTION: MCI-N, W, F, B, C | 4. AGE: | 5. DATE OF BIRTH: | 6. SEX: Male_____ Female_____ |
|---|---|---|---|

| 7. CIVIL STATUS: M_____ S_____ D_____ W_____ | 8. RACE CAU_____ BL_____ OTHER_____ | 9. EXAMINING FACILITY:_____ |
|---|---|---|

10. PURPOSE OF EXAMINATION:

11. NAME OF ADDRESS OF NEXT OF KIN FOR EMERGENCY NOTIFICATION (Optional):

MEASUREMENTS

| 12. HEIGHT:_____ | 13. WEIGHT: _____ | 14. COLOR OF HAIR:_____ | 15. COLOR OF EYES:_____ |
|---|---|---|---|

BUILD: Slender_____ Medium_____ Heavy_____ Obese_____

17. BLOOD PRESSURE:

| | Sitting | Standing |
|---|---|---|
| Right arm | | |
| Left arm | | |

| 18. TEMPERATURE: | 19. RESPIRATORY RATE: _____/min. | 20. PULSE: Apical _____/min. Radial___/min. Reg____or Ir___ |
|---|---|---|

CLINICAL EVALUATION

NORMAL - NL ABNORMAL - ABNL NOT EXAMINED - NE

| NL | | ABNL | NE | PHY. REMARKS BY APPROPRIATE NO. |
|---|---|---|---|---|
| | 21. Head, face, scalp..... | | | |
| | 22. Eyes: A. Visual Acuity..... | | | |
| | B. Conjunctive, sclera, cornea..... | | | |
| | C. Ocular, motility..... | | | |
| | D. Fundoscopic..... | | | |
| | E. Visual fields..... | | | |
| | 23. Ears (Pinna, canals, drums)..... | | | |
| | 24. Nose..... | | | |
| | 25. Sinuses..... | | | |
| | 26. Mouth & Throat..... | | | |
| | 27. Neck (Thyroid, nodes)..... | | | |
| | 28. Chest wall (Breasts)..... | | | |

| | ABN. | N | REMARKS BY APPROPRIATE NO. |
|---|---|---|---|
| 29. Lungs | | | |
| 30. Heart: A. Rate and rhythm | | | |
| B. Impulse location & character | | | |
| C. Sounds (S1, S2, gallops, murmurs) | | | |
| 31. Pulses (Radial, carotid, femoral) | | | |
| 32. Abdomen (Appearance, bowel sounds) | | | |
| 33. Viscera (Liver, spleen, kidney) | | | |
| 34. Genitalia (Hernia, testes, circumcision | | | |
| 35. Extremities (Cyanosis, clubbing, edema) | | | |
| 36. Back | | | |
| 37. Joints (Range of motion) | | | |
| 38. Skin | | | |
| 39. Lymph nodes (Axillary, inguinal, cervic) | | | |
| 40. Neurologic: A. Cranial nerves | | | |
| B. Gait, posture, movement | | | |
| C. Sensory | | | |
| D. Motor | | | |
| E. Reflexes (Babinski) | | | |
| F. Cerebellar | | | |
| 41. Rectal | | | |
| 42. Prostate | | | |
| 43. Pelvic: A. Vulva | | | |
| B. Vagina | | | |
| C. Cervix | | | |
| D. Uterus | | | |
| E. Adnexa | | | |

SUMMARY OF FINDINGS AND IMPRESSIONS; DIAGNOSIS LISTED NUMERICALLY:

1.

2.

3.

4.

TREATMENT RECOMMENDATIONS; (When possible please label treatment recommendation with number corresponding to diagnosis):

| | Date Completed |
|---|---|
| 1. | 1. |
| 2. | 2. |
| 3. | 3. |
| 4. | 4. |

| NEXT APPT. | 47. SIGNATURE OF PHYSICIAN: | 48. DATE: |
|---|---|---|

SOCIAL HISTORY (To be completed by Examining Physician)

A. Drinking History:

B: Smoking History: Cigarettes_____Packs per day_____

Years_____ Cigars_____Pipes_____

C. Use of Drugs: Heroin_____Narcotics____Barbituates___

Amphetamines_____

D. Special Dietary Needs: Bland____Low Fat_____Low salt___

Diabetic_____

E. Military Service: Which service?_____ When_____

Where _____

F. Immunizations(Approximate dates) or disease

Diphtheria _____ Tetanus _____

Tetanus Booster _____

Polio _____

Measles _____

Mumps_____

Rubella _____

Pneumonia _____

APPENDIX E(2)

SOCIAL HISTORY (To be Completed by Examining Physician)

A. Drinking history:

B. Smoking History: Cigarettes _____ Packs per day _____ Years ____ Cigars ___ Pipe _____

C. Use of drugs: Heroin _____ Narcotics _____ Barbituates ____ Amphetamines _____

D. Special dietary needs: Bland ____ Low fat _____ Low Salt _____ Diabetic _____

E. Military Service: Which Service _____ When _____ Where _____

F. Immunizations (Approximate dates)

Diphtheria _____ Tetanus _____ Polio _____ Flu _____ Rubella _____

APPENDIX H

**MEDICAL CONFIDENTIAL**

# Medication Log Sheet

Name_____ I.D. #_____

| Date | Medication | Time dispensed and initials (giver & inmate) | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Time | Given by: Init. | Inmate Init. | Time | Given by: Init. | Inmate Init. | Time | Given by: Init. | Inmate Init. | Time | Given by: Init. | Inmate Init. |
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(after completion—file with the medical record)

APPENDIX I

# PHYSICIAN'S ORDERS

NAME

ROOM NO.
(ADDRESS)

HOSP. NO.

PHYSICIAN

Drug Allergies

| Date & Time | Another brand of drug identical in form and content may be dispensed unless checked ☐ | | Nurse's Initials |
|---|---|---|---|
| | | | |
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PLEASE! USE BALL POINT PEN ONLY

PHYSICIAN'S ORD