

STATE OF NEW YORK - DEPARTMENT OF CORRECTIONS AND COMMUNITY SUPERVISION
HEALTH SCREENING FOR INTRASYSTEM/SHU TRANSFER

(Please print)

INMATE NAME _____ DOB _____ DIN _____

FACILITY _____ DATE OF ASSESSMENT _____ ALLERGIES _____

| General Health Instructions | | | |
|--|--------------------------|--------------------------|--|
| For any question with a YES response submit an appropriate referral. | | | |
| GENERAL HEALTH (A): INQUIRY & RESPONSE FROM THE INMATE | <u>Yes</u> | <u>No</u> | <u>Comments</u> |
| Do you have a current health problem or complaint? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Do you take any medications? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Is there a possibility that you are pregnant? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Do you have a current vision problem? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Do you have a current hearing problem? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Do you have a current dental problem? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Do you want an HIV Test? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Do you have a current advanced directive? (for example: DNR, Health Care Proxy etc.) | <input type="checkbox"/> | <input type="checkbox"/> | |
| If no, would you like more information? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Are you currently, or have you been, under care for Gender Dysphoria/ Gender Identity Disorder? | <input type="checkbox"/> | <input type="checkbox"/> | If response is Yes, confirm diagnosis on problem list. |
| Are you currently, or have you been, under care for an intersex medical condition? | <input type="checkbox"/> | <input type="checkbox"/> | |
| GENERAL HEALTH (B): OBSERVATION OF GENERAL HEALTH | <u>Yes</u> | <u>No</u> | <u>Comments</u> |
| Does the inmate have tremors? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Is there any evidence of abnormal sweating? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Are there any body deformities or amputations? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Can inmate ambulate without assistance? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Is their skin color/turgor good? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Are there any lesions or rashes? | <input type="checkbox"/> | <input type="checkbox"/> | |
| PREA (PRISON RAPE ELIMINATION ACT) Instructions | | | |
| For any question with a YES response marked with "****": | | | |
| - notify the Watch Commander Immediately. | | | |
| - refer to Health Services Policy 1.60 and 1.12B and take appropriate action. | | | |
| - use this form to submit a regular referral to Mental Health; if there is imminent risk for self harm or injury to others, use this form to submit an immediate referral to Mental Health and place on suicide watch. | | | |
| PREA: INQUIRY & RESPONSE FROM THE INMATE | <u>Yes</u> | <u>No</u> | <u>Comments</u> |
| Have you been sexually abused or victimized since your last transfer? | <input type="checkbox"/> | <input type="checkbox"/> | *** |
| Have you been forced, extorted or solicited to have sex in exchange for something since your last transfer? | <input type="checkbox"/> | <input type="checkbox"/> | *** |
| Have you been approached to have sex with a staff person since your last transfer? | <input type="checkbox"/> | <input type="checkbox"/> | *** |
| | | | |

| Mental Health Instructions: | | | | |
|---|--------------------------|--------------------------|--------------------------|-----------------|
| - For any response in a section marked with ***, appropriate action must be taken as noted in each question (As determined by the Watch Commander.) | | | | |
| - Notify the Watch Commander whenever an immediate referral is made. | | | | |
| - If there is imminent risk for self harm or injury to others, notify Mental Health immediately and place on suicide watch. | | | | |
| MENTAL HEALTH (A): INQUIRY & RESPONSE FROM THE INMATE | <u>Yes</u> | <u>No</u> | <u>Refused</u> | <u>Comments</u> |
| 1. Do you have a history of Mental Health Treatment? (Inpatient/Outpatient) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2. Were you ever prescribed mental health medications? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3. Are you a current mental health patient? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4. Do you have a current mental health complaint? "Yes" – <u>REGULAR REFERRAL</u> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5. Do you take any mental health medications? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 6. Do you feel you have anything to look forward to in the future? "No" or "Refused" – <u>IMMEDIATE REFERRAL & Assess and Consult with Watch Commander to determine appropriate action</u> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | *** |
| 7. Do you want to hurt yourself? "Yes" or "Refused" – <u>IMMEDIATE REFERRAL & Assess and Consult with Watch Commander to determine appropriate action</u> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | *** |
| 8. Do you want to hurt someone else? "Yes" or "Refused" – <u>IMMEDIATE REFERRAL & Assess and Consult with Watch Commander to determine appropriate action</u> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | *** |
| 9. Have you attempted suicide while incarcerated? "Yes" or "Refused" – <u>IMMEDIATE REFERRAL & Assess and Consult with Watch Commander to determine appropriate action</u> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | *** |
| 10. Have you been thinking about suicide? "Yes" or "Refused" – <u>IMMEDIATE REFERRAL & Assess and Consult with Watch Commander to determine appropriate action</u> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | *** |
| MENTAL HEALTH (B): OBSERVATION OF MENTAL HEALTH | <u>Yes</u> | <u>No</u> | | <u>Comments</u> |
| 11. Inmate has visible scars and marks of self mutilation. "Yes" – <u>IMMEDIATE REFERRAL & Assess and Consult with Watch Commander to determine appropriate action</u> | <input type="checkbox"/> | <input type="checkbox"/> | *** | |
| 12. Is inmate's appearance and grooming acceptable? "No" – <u>REGULAR REFERRAL</u> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| 13. Does inmate appear anxious? "Yes" – <u>REGULAR REFERRAL</u> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| 14. Is inmate oriented to time, place and person? "No" – <u>IMMEDIATE REFERRAL & Assess and Consult with Watch Commander to determine appropriate action</u> | <input type="checkbox"/> | <input type="checkbox"/> | *** | |
| 15. Does inmate exhibit aggressive behavior? "Yes" – <u>REGULAR REFERRAL</u> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| 16. Is inmate acting and/or talking in a strange manner (e.g., cannot focus attention, hearing or seeing things which are not there)? "Yes" – <u>IMMEDIATE REFERRAL & Assess and Consult with Watch Commander to determine appropriate action</u> | <input type="checkbox"/> | <input type="checkbox"/> | *** | |

INMATE NAME (Please Print) _____ DOB _____ DIN _____

| DISPOSITION | |
|---|--------------------------|
| General Population | <input type="checkbox"/> |
| Regular Referral to Mental Health | <input type="checkbox"/> |
| Immediate Referral to Mental Health Clinician | <input type="checkbox"/> |
| Immediate Referral to Medical Clinician | <input type="checkbox"/> |
| Referral to Dentist | <input type="checkbox"/> |
| Placed on suicide watch | <input type="checkbox"/> |
| Notified Watch Commander | <input type="checkbox"/> |
| <p>If regular OMH referral, how was notification made? <input type="checkbox"/> phone <input type="checkbox"/> in-writing <input type="checkbox"/> in-person</p> <p>If immediate OMH referral name and title of clinician contacted is required:</p> <p>Name _____ Title _____</p> <p>Date _____ Time _____</p> | |
| DOCUMENTATION (Check List) | |
| <p>If Mental Health referral is indicated:</p> <p>Yellow copy sent to OMH in place of Mental Health Referral Form #3150. <input type="checkbox"/></p> <p>OMH Unit Chief and Watch Commander notified by phone (for immediate referrals). <input type="checkbox"/></p> | |
| OTHER COMMENTS – | |
| <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> | |

Signature of RN _____ Provider # _____ Date _____ Time _____

| | | | |
|--|-------|-----------------|--|
| TO BE COMPLETED BY MENTAL HEALTH UNIT (If referral is requested): | | | |
| Inmate: _____ was seen on _____ by OMH staff. | | | |
| COMPLETED BY: _____ | | | |
| Name | Title | Phone Extension | |

This information is protected under NYS PHL Law 27-F prohibiting further disclosure. A general authorization is not sufficient for release.
 The source of a mental health referral and information provided on the referral may be protected from disclosure under Section 33.13 and 33.16 of the Mental Hygiene Law, if such disclosure could be detrimental to the referral source, to the patient, or other persons.

White: Health Record (*Interfile* (file inside - in reverse chronological order) in AHR section) Yellow: Mental Health Unit Chief (if referral is indicated)