FORM 3276 (11/15)

STATE OF NEW YORK
DEPARTMENT OF CORRECTIONS AND COMMUNITY SUPERVISION
DIVISION OF HEALTH SERVICES

IRC-Complete heading, add names and numbers, then forward to Health Services Unit

INMATE HEALTH CARE TRANSIT FORM

From: _____ Correctional Facility Date(s) of Transit: _____

Intransit Facilities (if applicable) _____

To: _____ Correctional Facility

MED Staff- Complete this column following instruction below, and return to IRC at least 24 hrs prior to departure.

NAME	NUMBER	MEDICAL CONCERN *

_____ _____
Signature of Health Staff completing form Date

* The following information is listed in this column:

1. **Medication**
   a) The next scheduled day and time for medication
   b) The medication times per day
2. **Inmate allergies**
3. **If the inmate has one of the following diseases indicate by letter:**
   a) Diabetes c) Breathing Disorder e) Dental Problem g) Dialysis
   b) Heart Disease d) Seizure Disorder f) Category Specific Precautions** (i.e., Respiratory, Contact, Enteric, Drainage)

DO NOT LIST ANY OTHER DISEASES IN THIS COLUMN

4. **Mobility Devices (e.g., wheel chair, cane, crutches, walker)**
5. **Medical Equipment (e.g., CPAP, TENS, eyeglasses, special issue boots)**

**N.B. It is recommended that Universal Blood and Body Fluid Precautions be consistently used for all individuals.

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