HEALTH TRANSFER INFORMATION PURSUANT TO SECTION 601 (a) CORRECTION LAW

This form is completed when the health record does not accompany the inmate and is necessary to provide continuity of care.

Health Care Staff (if available) place the form in a sealed envelope "Confidential – Health Information" indicating Inmate name, sending facility and receiving facility.

The sending facility calls the receiving facility if inmate requires 24 hour nursing care and/or possible hospitalization to an acute center.

Attach *Suicide Prevention Screening Guideline Form* from intake, if available.

NAME _____ D.O.B. _____ DIN _____ NYSID_____
Last First

HEALTH INFORMATION

A Physical assessment has ☐ has not ☐ been completed.

	No	Yes	Date of Last Incidence		No	Yes	Date
Asthma or Breathing Disorder	_____	_____	_____	CXR	_____	_____	_____
Diabetes	_____	_____	_____	Tetanus	_____	_____	_____
Heart Disease	_____	_____	_____	Pap smear	_____	_____	_____
Hepatitis	_____	_____	_____	HIV Tested	_____	_____	_____
Seizure Disorder	_____	_____	_____	Result _____			
Syphilis	_____	_____	_____	PPD Date _____ mm. Anergic _____			
Hypertension	_____	_____	_____	Treated _____			
IVDA	_____	_____	_____	VDRL Date _____ Neg _____ Pos _____			
				Treated _____			
Last Drug Used	_____			G.C. Smear Date _____ Neg ____ Pos ___			
				Treated _____			

Allergies _____

Dental Problems? No _____ Yes _____ Explain _____

List Medications _____

MENTAL HEALTH INFORMATION

1. Is the inmate currently receiving mental health services? Yes _____ No _____
   If yes, problem: _____
   Name of TX provider: _____ *Telephone:* _____
2. Is the inmate currently housed in a mental observation cell and/or under increased supervision for MH reasons? Yes ____ No ____ Reasons: _____
3. Has the inmate been on suicide watch? Yes ____ No ____ Last Date: _____
   Suicide attempt(s)? Yes ____ No ____ Last Date: _____
   Has the inmate made suicidal statements/gestures: Yes ____ No ____ Last Date: _____
4. History of self mutilation? Yes ____ No ____ Explain: _____
5. Past known psychiatric hospitalization? Yes ____ No ____ hospital and date: _____
6. Current mental health related medications (dosage, date of last dose)? _____

Additional information related to current treatment should be noted, e.g., current medications, significant lab work, any information related to TB tx - such as sputum tests including pending reports with lab test numbers for follow-up. Any information regarding work disabilities, prosthesis, hearing, blindness, previous hospitalization should also be noted. Use reverse side if needed. _____

_____

_____

_____

Signature Facility Phone# (with extension) Date

White - Envelope 3272 with inmate Canary - Intransit Facility Pink - Inmates Ambulatory Health Care Record Misc. Div.

FORM 3611 (02/98)