OFFENDER NAME:	
ID NUMBER:	DATE OF BIRTH:

TRANSFER OF OFFENDER – HEALTHCARE

DATE OF TRANSFER	TRANSFERRING FROM:	TRANSFERRRING TO:

Length of time in custody: ____________________ ☐ Health records transferred with patient

☐ No health records available ☐ Contact for health records: ____________________

Diagnoses/Problem List: ☐ None

Recent medical, dental, and mental health encounters (include details): ☐ None

Follow-up required (explain as needed): ☐ None

☐ Chronic Care ☐ Mental Health ☐ Infection Prevention ☐ Other (explain below)

Current treatment (explain as needed, including projected end dates): ☐ None

☐ Hepatitis C ☐ Tuberculosis ☐ MRSA ☐ Substance abuse ☐ Medication-assisted treatment

☐ Other (explain below)

Pertinent positive and negative lab, x-ray, and other diagnostic findings: ☐ None

Mental health concerns, including current suicidality and past history: ☐ None

Behavior concerns: ☐ None

TRANSFER OF OFFENDER – HEALTHCARE – PAGE 2 OF 2	OFFENDER NAME	DOC NUMBER	RECEPTION DATE

Authorized accommodations/limitations (explain as needed): ☐ None

☐ Hearing aids ☐ Glasses ☐ Contacts ☐ Dentures ☐ Partials
☐ Walker, cane, crutches ☐ Wheelchair ☐ Bed-bound ☐ Lower bunk ☐ No stairs
☐ Artificial limbs ☐ Special diet (explain below) ☐ Other (explain below)

Medications: ☐ None

☐ No meds ☐ Med list attached ☐ En route medications to be distributed by officers during transport (list below)
☐ Keep on person (KOP) meds: ☐ Inhaler ☐ Nitro ☐ Other (list below)

ALLERGIES (meds or food) ☐ **None**	**HEPATITIS / TETANUS** ☐ **None**	**TST / TB** ☐ **Not tested**
	Hepatitis A Series (dates given)**:**	Date TST read: ____________
	1)____________ 2)____________	Results: ________ millimeters
	Next Due: ______________	Symptom screening date: ___________
	Hepatitis B or A/B Series (dates given)**:**	Results: ________________________
	1)____________ 2)____________	Chest x-ray date: ____________
	3)____________ Next Due:___________	Results: ________________________
		Completed treatment (INH): Yes / No
	Date of last tetanus: _____________	Date: ____________

COMPLETED BY (stamped/printed name and signature)	DATE COMPLETED

Form date 11.27.2017