OKLAHOMA DEPARTMENT OF CORRECTIONS

Medical Transfer Request to Assessment & Reception

Date: _____ **Time:** _____

Requesting Facility: _____ **Phone #:** (____)_____

Contact Person: _____ **Fax #:** (____)_____

Inmate Name: _____ **Gender:** ☐ M ☐ F

SSN: _____ **DOB:** _____ **Judgment and Sentence Date:** _____

Primary Diagnosis: _____

Severity Classification: ☐ Mild ☐ Moderate ☐ Severe

Mental Health Diagnosis: _____

Severity Classification: ☐ Mild ☐ Moderate ☐ Severe

Check all that apply:

Orthoses/Prostheses: ☐ None ☐ Braces ☐ Shoe Inserts ☐ Hand/Leg Splints ☐ Limbs ☐ Other: _____

Aides of Impairment: ☐ None ☐ Glasses ☐ Walker ☐ Cane ☐ Crutches ☐ Wheelchair ☐ Hearing Aide(s)

Impairments: ☐ None ☐ Mental ☐ Speech ☐ Hearing ☐ Vision ☐ Sensation

Activity Limitation: ☐ None ☐ Moderate ☐ Severe

Pending Appointments: ☐ None Date: ____/____/____ Time: _____ AM PM **Location:** _____

Medical Justification for Transfer: _____

_____

_____

_____

_____

_____

_____

_____

_____

Hospitalizations: ☐ Currently in hospital ☐ Recent hospitalization **Name of Hospital:** _____

State reason: _____

_____

Name of person completing form: _____ **Title:** _____

*** Email completed form to:** janet.walker@doc.ok.gov & savanna.jones@doc.ok.gov

NOTE: Supporting documentation (medication list, providers notes, hospital/ER documentation if applicable) is required in order to make an informed decision on whether the inmate qualifies for consideration for transfer to A & R.

To be completed by Medical Services Office:

Received by: _____ **Date:** _____

Medical transfer approved: ☐ **Yes** ☐ **No If "No" state reason:** _____

_____

Comments: _____

_____

_____

Date Assessment & Reception notified: _____