

**OKLAHOMA DEPARTMENT OF CORRECTIONS  
MEDICAL SERVICES  
MEDICAL PAROLE/COMMUTATION CLINICAL RECOMMENDATION**

OFFENDER NAME \_\_\_\_\_ DOC NO. \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_

RECOMMENDING PROVIDER \_\_\_\_\_ FACILITY/DISTRICT \_\_\_\_\_

Diagnosis:

\_\_\_\_\_  
\_\_\_\_\_

Treatment Regimen:

\_\_\_\_\_  
\_\_\_\_\_

Prognosis:

\_\_\_\_\_  
\_\_\_\_\_

Functional Ability: (Check all that apply)

Can Walk	0-15 ft. <input type="checkbox"/>	one block <input type="checkbox"/>	unlimited <input type="checkbox"/>
Can Lift	0 lbs <input type="checkbox"/>	15 Lbs <input type="checkbox"/>	50 Lbs <input type="checkbox"/>
Dementia	Absent/Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>

Home Offer Address (if the address is a PO Box, must include directions), Phone Number and Any Contact Names:

\_\_\_\_\_  
\_\_\_\_\_

Continuity of Medical Care (must include where and how offender will access medical care following discharge):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Additional Information:

\_\_\_\_\_  
\_\_\_\_\_

Signature of Provider:

Date:

\_\_\_\_\_

\_\_\_\_\_

**NOTE: Prior to completing this form, the offender must sign an "Authorization for Release of Protected Health Information Form" (DOC 140108A)**