

**OKLAHOMA DEPARTMENT OF CORRECTIONS
DISCHARGE HEALTH SUMMARY**

Check all that Apply:

- No identified health problems –routine care only
- One or more well-controlled chronic health problems
 - Needs medication
 - Needs primary care follow-up in 3 to 6 months
 - Needs specialty follow-up. Specialties: _____
- One or more poorly-controlled chronic health problems
 - Needs medication
 - Needs primary care follow-up within 2 months
 - Needs specialty follow-up within 1 month. Specialties: _____
- Has urgent need health problem needing follow-up care
Specialties: _____

Mental Health Level: _____

Drug/Food Sensitivities and Allergies: <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" list	
Discharge Medications: <input type="checkbox"/> Yes <input type="checkbox"/> No List Below: Note: If inmate is on insulin document syringes	
1.	5.
2.	6.
3.	7.
4.	8.

- Aides of Impairment:** None Glasses Walker Braces Hand/Leg Splints Wheelchair Hearing Aide(s)
- Impairments:** None Mental Speech Hearing Vision Sensation
- Activity Limitation:** None Moderate Severe

Brief Summary of Current Health Problems: _____

Date of Last: TB Test: _____ TB Med. Initiated: _____ TB Med. Completed: _____ HIV Test: _____
 Influenza: _____ Pneumococcal: _____ Tetanus: _____ Medical Examination: _____
 Mammogram: _____ Pap smear: _____ PSA: _____ DNA: _____

Recommended Community Resources: Yes No List Below:

The above information has been explained to me by the health services staff, and I acknowledge that I have been advised of the necessary follow-up services needed to treat my health problems after I leave the custody of the Department of Corrections.

FOR CLOSED MEDICAL RECORDS CONTACT:
 Kate Barnard Community Correctional Center
 Sentence Administration and Offender Record Unit
 3300 Martin Luther King Avenue
 Oklahoma City, Oklahoma 73111

The above health care information will only be released through the authorization of the inmate in accordance with OP 140108 entitled "Privacy of Health Information".

"Release of Protected Health Information" DOC 140108A signed by inmate: Yes No N/A

Copy of "Tuberculosis & Immunization History Record" DOC 140301B given to inmate: Yes No

Inmate Signature: _____ DOC #: _____ Date: _____

Qualified Health Care Professional: _____ Date: _____

Inmate Name: _____ DOC #: _____ Date: _____