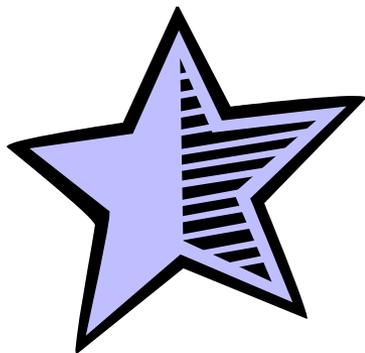


Lesson Plan: DOC 140113B - Intra-System Transfer Health Screening



Policy OP-140113

Facility Receiving Intra-system Transfer

Each inmate received by a facility, through intra-facility transfer, will receive a health screening immediately upon arrival by facility staff who are trained to perform this procedure. Facility staff will use the “Intra-System Transfer Health Screening” (DOC140113B) to document the results of the health screening, including needed referrals.

Intra-System Transfer Health Screening Form DOC 140113 B

Performance Objectives:

- At the end of this presentation, staff will be able to complete an Intra-System Transfer Screening Form for a new arrival.

INTRA-SYSTEM TRANSFER HEALTH SCREENING

Health/Mental Health trained staff will complete the health screening immediately upon offender arrival at the receiving institution. Route to the health service unit within 24 hours of the offender's reception for review and inclusion into medical record. Refer to Mental Health if "Yes" to any mental health question and/or indications including abuse and/or sexually aggressive behavior.

- Do you have hearing or vision problem? YES NO
- Are you currently being treated for any medical, mental, or dental problems? YES NO
(4-4370 b-1, 4-4370 b-3, 4-ACRS 411.08 b-1, 2, 3) (check box if none, STD, Cancer, etc.)
- Are you currently taking any medications? If "Yes", health assess. (i.e. blood pressure, psychiatric, etc.) YES NO
(4-4363 b-2, 4-4370 b-3)

Check One: Medication in Offender Property Medication with Health Record No Medication Received
If medication received, list medication:

- Do you have any medical, mental, or dental problems other than above mentioned? YES NO
(4-4363 b-3, 4-4370 b-4, 4-ACRS 40-09 b-3)
- Do you require assistance to stand or walk? YES NO
- Have you ever attempted or had thoughts of suicide? YES NO
(4-4370 b-1, 2, 4-ACRS 40-09 b-3)
- Have you ever had psychiatric treatment inpatient or outpatient? YES NO
- Do you have a history of substance abuse? YES NO
If "Yes", alcohol or drug type, route of use, amount used, frequency and duration of last use included on "Medical/Mental Health Screening (DOC 140113A)" (4-1862M b-1, 4-ACRS 40-09 b-4)
- Have you ever been a victim of abuse? (mental health) YES NO
If "Yes" check all that apply: Sexual Physical Mental
- Have you ever had a potential for violence or sexually aggressive behavior? YES NO
- Does the offender have any visual evidence of physical abuse: bruises, lacerations, rashes, jaundice, laceration, physical deformities, trauma and/or needle marks or other indications of drug abuse? (4-4363 b-5, 4-4370 b-5, 4-ACRS 40-09 b-7, 8)
- General appearance and behavior (4-4363 b-4, 4-4370 b-6, 4-ACRS 40-09 b-6)

Good Sweating Tremors Anxious Nervous Consciousness Conduct Other: _____

Comments: _____

MENTAL STATUS: (check appropriate status)

Offender can state name, place, and time
 Offender cannot state name, place, and time
 Offense shows symptoms of psychosis, depression, anxiety and/or aggression (4-4370 b-10, 4-ACRS 40-09 b-9)

DISPOSITION: (check as appropriate)

To General Population (no referral to health/mental health services) (4-4363 b-7, 4-4370 b-11)
 To General Population (with referral to health/mental health services) (4-4363 b-8, 4-4370 b-12)
 To Special Housing
 To Health/Mental Health Services (4-4363 b-9, 4-4370 b-13)

VERBAL AND WRITTEN ORIENTATION SHEET GIVEN TO OFFENDER (4-4344) Offender's Initials: _____ YES NO

NUMBER OF MEDICAL JACKETS RECEIVED: (Circle one) 0 1 2 3 4

CASE OF EMERGENCY NOTIFY:

Name: _____ Relationship: _____
 Address: _____ Phone: (____) _____

Screening Date: _____ Time: _____
 Reviewed By: _____ Date: _____ Time: _____
(Qualified Health Care Professional Signature) (Please Print Name)

Transferring Facility: _____ Receiving Facility: _____
 Offender's Name: _____ DOC #: _____
(Last, First)

Screening Form Lesson Plan

1. Determine if the **inmate** has any hearing or vision problems.
2. Determine if the **inmate** is currently being treated for any medical, mental, or dental problems.
3. Determine if the **inmate** is currently taking any medications. If yes, determine where the medication is located.
4. Determine if the **inmate** has any medical, mental, or dental problems other than above mentioned.

Screening Form Lesson Plan

5. Determine if the **inmate** requires assistance to stand or walk.
6. Determine if the **inmate** has ever attempted or had thought of suicide.
7. Determine if the **inmate** has ever had inpatient or outpatient psychiatric treatment.
8. Determine if the **inmate** has a history of substance abuse.

Screening Form Lesson Plan

9. Determine if the **inmate** has ever been a victim of abuse.
10. Determine if the **inmate** had or has a potential for violence or sexually aggressive behavior.
11. Determine if the **inmate** has any visual evidence of physical abuse, bruises, lesions, rashes, jaundice, infestation, physical deformities, trauma and/or needle marks or other indications of drug abuse.
12. Determine the **inmate** general appearance and behavior and select the appropriate description.

Screening Form Lesson Plan

Mental Status

- Determine if the **inmate** can state name, place and time.
- Determine if the **inmate** shows any symptoms of psychosis, depression, anxiety and/or aggression.

Screening Form Lesson Plan

Disposition

- If no services are needed, select General Population (no referral to health/mental health services).
- If a referral to medical for health or mental health is needed, select General Population (with referral to health/mental health services)
- If Special Housing is needed to accommodate **inmate**, then select Special Housing.
- To Health/Mental Health Services should be selected if the **inmate** is in need of health or mental health services in addition to the housing disposition.

Screening Form Lesson Plan

Verbal and Written Orientation Given to inmate

- The **inmate** must initial the form to indicate that he has received new arrival orientation and circle Yes or No.

Emergency Contact

- The **inmate** must complete the emergency contact information.

Screening Form Lesson Plan

Employee Signature

- The employee screening the new arrival will sign as Screener's name and title along with the date and time of the screening interview. Please write the **inmate** name and DOC # at the bottom of the page.

Form completion

- Please completely fill out the screening form (DOC140113B) and forward the form to medical within 24 hours for review and inclusion into the **inmate** medical record.

Written orientation to medical services will be given to each **inmate** during the orientation process.

What happens **in the** next 24 hours?

- Review of the “Intra-System Transfer Health Screening”, “Medical Transfer Summary”, and the **inmates** medical record will be performed by QHCP to ensure continuity of care and proper placement. The QHCP will document that a healthcare record review was completed by the next working day of the **inmates** arrival.
- If the facility medical provider believes an **inmate** has transferred to their facility inappropriately, the medical provider or designee will notify the chief medical officer of designee by completing the “Medical Transfer Request” with supporting documentation.
- The facility’s qualified mental health provider will be notified by medical services by the next working day of any **inmate** whose records indicate any mental health concerns and/or whose mental health classification is MH-B, MH-C1m MH-C2 or MH-D for further screening and assessment. The QMHP will document that a healthcare chart review was completed by the next working day of the **inmates’** arrival.