

**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:

Medical Services Administration
 2901 N. Classen Blvd. Suite 200
 Oklahoma City, OK 73106
 Phone: 405-962-6155

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".

A blank "Release of Protected Health Information" form DOC 140108A given to inmate: Yes No N/A
If no, state reason: _____

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

Inmate Signature: _____ DOC #: _____ Date: _____

Qualified Health Care Professional: _____ Date: _____

Inmate Name: _____ DOC #: _____ Date: _____

Original: Chart
 Copy: Inmate
 Copy: Field File (if authorized for release)