

OKLAHOMA DEPARTMENT OF CORRECTIONS MEDICAL TRANSFER SUMMARY

TRANSFERRING SECTION

Transferred From: _____ Transferred to: _____ Time: _____ AM PM Date: ____/____/____

Allergies (Drug & Food): _____ Dietary Requirement: _____

Current Acute Condition/Problem: Yes No If "Yes" describe _____

Requires Chronic Illness Management: (Check as applicable/specify date of last evaluation) (4-ACRS-4C-06 b-5)

None Seizure Disorder ____/____/____ Inf. Disease ____/____/____
 Cardiovascular ____/____/____ Respiratory ____/____/____ COPD ____/____/____
 Diabetes ____/____/____ CAD ____/____/____ Other: _____

Current Medication(s): None

Name of Drug (4-4414 b- 4)	Dosage/Route	Frequency	Medication Sent with Patient
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

(Continuation of medications on back)

Orthoses/Prostheses: None Braces Shoe Inserts Hand/Leg Splints Limbs Teeth Heart Valve Artificial Eye

Aids of Impairment: None Glasses Walker Wheelchair Hearing Aid(s)

Impairments: None Mental Speech Hearing Vision Sensation

Activity Limitation: None Moderate Severe

Specialty Referrals/Pending Appointments: None Date: ____/____/____ Time: _____ AM PM Location: _____
(Enter change of facility on Medsynergy)

Pending Laboratory/ X-rays: None Date: ____/____/____ Time: _____ AM PM Location: _____

Mental Health Concerns: (ACRS-4C-06 b-3) No Yes,

Explain _____

Date of next mental health appointment: ____/____/____

Date of Last: Physical Exam ____/____/____ HIV ____/____/____ Results: _____

TB Screening/PPD ____/____/____ Results: _____ TB Med. Initiated ____/____/____ X-ray sent with inmate: Yes No N/A
(4-4414, b-5)

Suitable for Transport: (4-4414 b- 3) Without Restriction With Restrictions Describe: _____

Current Health Summary: (4-ACRS-4C-06 b-3, 5) _____

Qualified Healthcare Professional Signature/Title

_____/_____/_____
Date

RECEIVING SECTION

Received By: _____ Received From: _____ Time: _____ AM PM Date: ____/____/____

Medical Chart Review Completed (pending appointments, labs, x-rays, chronic care, current PE): Yes No

Qualified Healthcare Professional Signature/Title

_____/_____/_____
Date

-Offender's Name:
(Last, First)

DOC #

Current Medication(s) Continue: Name of Drug	Dosage/Route	Frequency	Medication Sent with Patient	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No