

OKLAHOMA DEPARTMENT OF CORRECTIONS
MEDICAL TRANSFER REQUEST

Move Request: Medical Move Mental Health Move

Date: _____ Time: _____

Requesting Facility: _____ Requesting HSA/Provider: _____

Inmate Name: _____ DOC #: _____

SSN: _____ DOB: _____ Gender: M F

Security Level: Halfway House Work Center Community Minimum Medium Maximum

Current Activity/Housing Summary completed: Yes No (IHAP must accompany all "Medical Transfers Request")

IHAP Group Codes: MA _____ W _____ MH _____ O _____

Primary Diagnosis: _____

Severity Classification: Mild Moderate Severe

Secondary Diagnosis: _____

Severity Classification: Mild Moderate Severe

Clinical Justification for Transfer: _____

Requires Lower Bunk: Yes No Requires Lower Rung/Level: Yes No

Is inmate currently in hospital: Yes No If "Yes" where: _____

Palliative Care Eligible: Yes No DNR signed: Yes No Comments: _____

Emergency transfer: Yes No If "Yes" state reason: _____

Can inmate be transported by Central Transport Unit: Yes No **Note:** If inmate is wheelchair bound he can not be transported by CTU

* Fax completed "Medical Move Request" to **405-962-6147**.

* If medical move has not occurred within two weeks contact the medical services division at **405-962-6155**.

To be filled out by Medical Services Central Office:

Received by: _____ Date: _____

Medical transfer approved: Yes No If "No" state reason: _____

Comments: _____

Facility transferred to: _____ Date faxed to receiving provider: _____