OKLAHOMA DEPARTMENT OF CORRECTIONS
ASSESSMENT AND RECEPTION CENTER
MEDICAL TRANSFER SUMMARY
(A & R Only)

TRANSFERRING SECTION

Allergies (Drug & Food): _____

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

Current Medication(s): ☐ None

Name of Drug (4-4414 b # 4)	**Dosage/Route**	**Frequency**	**Medication Sent with Offender**
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Current Medical Problems: (4-ACRS-4C-06 b # 3, 5) _____

_____

_____

TB Boost: ☐ Yes ☐ No **DNA Completed:** ☐ Yes ☐ No **Date:** _____

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

_____ _____/_____/_____
Qualified Healthcare Professional Signature/Title **Date**

RECEIVING SECTION

Date Received: _____ **Time Received:** _____ **Dietary Requirement:** _____

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: _____

Orthoses/Prostheses: ☐ None ☐ Braces ☐ Shoe Inserts ☐ Hand/Leg Splints ☐ Limbs ☐ Teeth ☐ Heart Valve ☐ Artificial Eye
Aides of Impairment: ☐ None ☐ Glasses ☐ Walker ☐ Wheelchair ☐ Hearing Aide(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 MedUnison)

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 offender: ☐ Yes ☐ No ☐ N/A
(4-4414, b #5)

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

_____ _____/_____/_____
Qualified Healthcare Professional Signature/Title **Date**

Offender Name: **DOC #**
(Last, First)