

OKLAHOMA DEPARTMENT OF CORRECTIONS
REQUEST FOR HEALTH SERVICES

TO BE COMPLETED BY OFFENDER

Facility: _____ Date: _____

Offender Name _____ DOC # _____ Unit _____

I request the following service(s): (Check appropriate box(s))

- Medical Mental Health Dental Optometry (eye) Medication Renewal
(expired medications only)

Reason for service: _____

I understand that in accordance with operations memorandum OP-140117 entitled "Access to Health Care", I will be charged \$4 for each medical service I request and a charge of \$4 for each medication(s) dispensed to me, with the exceptions noted in the above-reference operations memorandum. There is no charge to the offender for mental health services and/or mental health medications.

Offender Signature _____ Date: _____

TO BE COMPLETED BY HEALTH SERVICES

Date Received

Initials

Comment: _____

Qualified Health Care Professional

Date

NOTE: All "Keep on Person" (KOP's) medication refill requests must be submitted to the facility's health services unit or to the medical host facility, using the "Medication Refill Slip" (DOC 140130M). "Medication Refill Slips" must be submitted within ten days of the date the medication expires or runs out. "Medication Refill Slips" are readily available and accessible at designated locations within the facility.