# INTAKE RECEIVING SCREENING BY CORRECTIONAL - TRAINED STAFF-SAMPLE

DETAINEE'S NAME:_____RACE/SEX:_____ DATE OF BIRTH:_____MOST SERIOUS CHARGES:_____

DATE:_____ TIME:_____ NAME OF SCREENING OFFICER:_____

**ALLERGIES:**_____ **Health Insurance: ____No ____Yes, Details:**_____

**1)** Does the inmate have visible signs of serious injury, bleeding, alteration in consciousness, respiratory distress, extreme pain distress, chest tightness, psychosis or other symptoms requiring emergency medical treatment? ____No ____Yes. If yes, refer immediately for care.

**2) Appearance:**

_____ Unremarkable _____ Chronically Ill
_____ Sweating _____ Uncomfortable / In Pain
_____ Tremors _____ Cachectic
_____ Anxious _____ Other:_____
_____ Disheveled

**3) Behavior:**

_____ Acceptable _____ Withdrawn
_____ Disorderly _____ Tearful
_____ Aggressive _____ Other:_____

**4) State of Consciousness:**

_____ Alert and oriented
_____ Intoxicated or drug impaired
_____ Altered consciousness
_____ Other:_____

**5) Ease of Movement:**

_____ Unremarkable _____ Body Deformities / Amputee
_____ Unsteady _____ Other:_____
_____ Paralysis

**6) Breathing:**

_____ Comfortable _____ Wheezing
_____ Coughing _____ Other:_____
_____ Hyperventilation

**7) Skin:**

_____ Free of lesions, open sores, serious rashes
_____ Evidence of recent injury (bruise, abrasion, etc)
_____ Abscess, boil, possible MRSA
_____ Needle Tracks _____ Surgical Scars
_____ Jaundice _____ Skin Ulcers
_____ Edema of extremities
Describe:_____

**8) Disabilities / Orthotics:**

_____ Walker / Wheelchair
_____ None _____ Wears glasses
_____ Cast _____ Eye contact lenses
_____ Crutches / Cane _____ Dentures
_____ Hearing Aid _____ Other:_____

**9)** Does the inmate's presentation suggest a risk of suicide?

_____Yes _____No

**Health Questionnaire:**

**1)** When was your last time in this jail system? _____ Year _____ Never

If previously in the jail: a) Were you ever in the mental health unit or on a suicide watch?

_____ No ____Yes, Details: _____

b) Were you in isolation for tuberculosis or MRSA or infectious disease?

_____ No ____Yes, Details: _____

**2)** Name and telephone numbers of emergency contact: _____

**3)** Are you currently ill or injured? ____No ____Yes, Details:_____

**4)** Have you had a head injury or loss of consciousness in the past 72 hours?

_____ No ____Yes, Details: _____

**5)** Have you been in the hospital or emergency room in the past 3 months?

_____ No ____Yes, Details: _____

**6)** When and where was your last health care visit _____

**7)** Do you have or ever had:

| | | | |
|---|---|---|---|
| a. Asthma | _____ No | ____Yes,Details | _____ |
| b. Diabetes | _____ No | ____Yes,Details | _____ |
| c. Epilepsy or Seizures | _____ No | ____Yes,Details | _____ |
| d. High Blood Pressure | _____ No | ____Yes,Details | _____ |
| e. Heart Condition | _____ No | ____Yes,Details | _____ |
| f. HIV or AIDS | _____ No | ____Yes,Details | _____ |
| g. Liver Disease or Hepatitis | _____ No | ____Yes,Details | _____ |
| h. Tuberculosis | _____ No | ____Yes,Details | _____ |
| i. Mental Health Conditions | _____ No | ____Yes,Details | _____ |
| j. Other:_____ | _____ No | ____Yes,Details | _____ |

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**8) List medications (medical and psychiatric) that you currently take or are supposed to take:**

| Medication | Condition | Date last taken |
|---|---|---|

| | | |
|---|---|---|
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**9)** Are you having:
Weight loss (more than 10 pounds in a month) ____No ____Yes
Cough (> 2 week) ____No ____Yes
Coughing blood ____No ____Yes
Heavy sweats at night time ____No ____Yes
Fever ____No ____Yes

**10)** Do you have any special health requirements?
(Such as dialysis, CPAP machine, special diet, etc.)
____No ____Yes, Details:_____

**11)** Do you have a "spider bite", sore, drainage, lice or scabies on your skin/scalp
____No ____Yes, Details:_____

**12)** Are you currently having blood from your rectum or black-colored stools?
____No ____Yes, Details:_____

**13)** Do you have any genital or pelvic lesions, discharge,
or pain? ____No ____Yes, Details:_____

**14)** Have you ever had or been exposed to chickenpox?
____No ____Yes, Details:_____

**15)** Do you have a painful dental condition?
____No ____Yes, Details:_____

**16)** Have you ever had problems withdrawing from alcohol including seizures or shakes?
____No ____Yes, Details:_____

**17a)** How much alcohol do you drink?
_____ Occasionally _____ Never
_____ Moderate: (Up to 6 beers or more than 1 pint daily)
_____ Heavy: (More than 6 beers or more than 1 quart daily)

IF SYMPTOMATIC, NOTIFY CLINICIAN.)

**17b)** When was your last drink?_____

**18) Do you currently use drugs? _____None**

| Type | Frequency | Amount | Last Use |
|---|---|---|---|
| ☐ Marijuana | ☐Daily ☐Often ☐Occasional | | |
| ☐ Cocaine | ☐Daily ☐Often ☐Occasional | | |
| ☐ Opiods (Heroin, morphine, OxyContin, Vicodin, Demerol, Codeine) | ☐Daily ☐Often ☐Occasional | | |
| ☐ Benzodiazepines (Valium, Xanax, Ativan) | ☐Daily ☐Often ☐Occasional | | |
| ☐ Stimulants or Hallucinogens (Ecstasy, LSD, Ritalin; Methamphetamines) | ☐Daily ☐Often ☐Occasional | | |
| ☐ GHB (Gammahydroxybutyrate) "Date Rape" | ☐Daily ☐Often ☐Occasional | | |
| ☐ Methadone | Phone number of program/counselor: | | |

If using drugs: a) Have you ever injected drugs? ____No ____Yes, in past ____Yes, recently
b) Have you ever had problems withdrawing from drugs including seizures? ____No ____Yes, Details: _____

**19) FEMALES:** a) Are you pregnant? ____No ____Yes ____Don't know b) When was your last menstrual period? _____
c) When was your last pregnancy? _____ d) Sexual assault in last 72 hours? _____

**COMMENTS:** _____

_____

**DISPOSITION:**

☐ Medical:___Routine____Urgent___Medication____Emergency___ ☐ General Population
☐ Mental Health Other:_____

"I have received instructions on access to medical , dental, and mental health care. All of my questions have been answered.

Inmate Signature: _____ Date: _____

Screening performed by:_____ Reviewed By:_____

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