FOR MEDICAL USE ONLY

Date Received: _____

Time Received: _____

CORRECTIONAL MEDICAL SERVICES
HEALTH SERVICES REQUEST FORM

Print Name: _____ **Date of Request:** _____

ID #: _____ Date of Birth: _____ Housing Location: _____

Nature of problem or request:

I consent to be treated by health staff for the condition described.

SIGNATURE

PLACE THIS SLIP IN MEDICAL REQUEST BOX OR DESIGNATED AREA

DO NOT WRITE BELOW THIS AREA

Triaged by: _____ Initials **Referred to:** (Circle ONE) NSC Mid-level SC Physician SC MH Dental
Other: _____

HEALTH CARE DOCUMENTATION

Subjective:

Objective: BP _____ T _____ P _____ R _____ Wt_____

Assessment:

Plan:

❒ Inmate education handout reviewed with and given to the patient.

Refer to: (Circle any applicable) Mid-level Physician MH Dental Other: _____

Signature & Title: _____ Date: _____ Time: _____