OKLAHOMA DEPARTMENT OF CORRECTIONS
DISCHARGE HEALTH SUMMARY

Check all that Apply:

- ☐ No identified health problems – routine care only
- ☐ One or more well-controlled chronic health problems
  - ☐ Needs medication
  - ☐ Needs primary care follow-up in 3 to 6 months
  - ☐ Needs specialty follow-up. Specialties: _____
- ☐ One or more poorly-controlled chronic health problems
  - ☐ Needs medication
  - ☐ Needs primary care follow-up within 2 months
  - ☐ Needs specialty follow-up within 1 month. Specialties: _____
- ☐ Has urgent need health problem needing follow-up care
  Specialties: _____

Mental Health Level: _____

Drug/Food Sensitivities and Allergies: ☐ Yes ☐ No If "Yes" list	
Discharge Medications: ☐ Yes ☐ No List Below: **Note:** If inmate is on insulin document syringes	
1.	5.
2.	6.
3.	7.
4.	8.

Aides of Impairment: ☐ None ☐ Glasses ☐ Walker ☐ Braces ☐ Hand/Leg Splints ☐ Wheelchair ☐ Hearing Aide(s)
Impairments: ☐ None ☐ Mental ☐ Speech ☐ Hearing ☐ Vision ☐ Sensation
Activity Limitation: ☐ None ☐ Moderate ☐ Severe

Brief Summary of Current Health Problems:

Date of Last: TB Test: _____ TB Med. Initiated: _____ TB Med. Completed: _____HIV Test: _____
Influenza: _____ Pneumococcal: _____ Tetanus: _____Medical Examination: _____
Mammogram: _____ Pap smear: _____ PSA: _____ DNA: _____

Recommended Community Resources: ☐ Yes ☐ No List Below:

The above information has been explained to me by the health services staff, and I acknowledge that I have been advised of the necessary follow-up services needed to treat my health problems after I leave the custody of the Department of Corrections.

FOR CLOSED MEDICAL RECORDS CONTACT:
Medical Services Administration
2901 N Classen Blvd, Ste 200
Oklahoma City, OK 73106
Phone: 405-962-6155

The above health care information will only be released through the authorization of the inmate in accordance with OP-140108 entitled "Privacy of Health Information."

A blank "Release of Protected Health Information" form DOC 140108A given to inmate: ☐ Yes ☐ No ☐ N/A If no, state reason: _____

Copy of "Tuberculosis & Immunization History Record" DOC 140301B given to inmate: ☐ Yes ☐ No
If "No" state reason: _____

Inmate Signature: _____ ODOC #: _____ Date: _____

Health care provider/RN/LPN: _____ Date: _____

Inmate Name: _____ ODOC #: _____ Date: _____

Original: Chart
Copy: Inmate
Copy: Field File (if authorized for release)