

**OKLAHOMA DEPARTMENT OF CORRECTIONS
HEALTH CARE PROVIDER ORDERS**

Allergies/Sensitivities: _____

Date/Time		
Inmate Name (Last, First): _____ ODOC #: _____ Location: _____		
Date/Time		
Inmate Name (Last, First): _____ ODOC #: _____ Location: _____		
Date/Time		
Inmate Name (Last, First): _____ ODOC #: _____ Location: _____		