OKLAHOMA DEPARTMENT OF CORRECTIONS
REQUEST FOR HEALTH SERVICES

TO BE COMPLETED BY INMATE **Facility:**_____ **Date:** _____

Inmate Name_____ **ODOC #**_____ **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 $4.00 for <u>each</u> medical service <u>I request</u> and a charge of $4.00 for <u>each</u> medication(s) dispensed to me, with the exceptions noted in the above-reference operations memorandum. There is <u>no charge</u> to the offender for mental health services and/or mental health medications.

Inmate Signature_____ **Date:** _____

TO BE COMPLETED BY HEALTH SERVICES

Date Received	Initials

Comment: _____

_____

_____ _____
RN/LPN/Health Care Provider Signature **Date**

"Return the "Request for Health Services" (DOC 140117A) with the disposition of the inmate's request in the comment section to the inmate after scanning into the inmate's EHR.

<u>NOTE:</u> 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.