OKLAHOMA DEPARTMENT OF CORRECTIONS

Rules for Health Care Leave and Medication
For Inmates Assigned to Community Corrections

The Oklahoma Department of Corrections will provide health care (i.e., medical, mental health, dental, vision care) to all inmates. I understand I have the right to choose to obtain my health care in the community and to be responsible for my health care expenses, including medication, as part of my reintegration to the community. I further agree by my signature that I understand and agree to the following rules and conditions.

_____ (Initials) Prior to making an appointment for health care in the community, I will complete a "Health Care Leave Request Form" (DOC 140121B) and the "Affidavit of Financial Responsibility for Medical, Mental Health, Dental and/or Vision Care" form (DOC 140121D) and submit to my assigned case manager at least ten working days prior to my anticipated appointment.

_____ (Initials) After meeting with my case manager, I will make an appointment with the community provider of my choice. The case manager will ensure the forms have been completed, verify the appointment time, date and determine whether the inmate is eligible for escorted leave. The "Health Care Leave Request Form" (DOC 140121B) and "Affidavit of Financial Responsibility for Medical, Mental Health, Dental and/or Vision Care" (DOC 140121D) will then be forwarded to Medical Services for review and signature. Once processed by Medical Services, the "Health Care Leave Request Form" (DOC 140121B) will be forwarded to the facility head or designee. I understand that the facility head or designee has the final authority to approve or deny my "Health Care Leave Request Form (DOC 140121B). If my leave is approved, the "Health Care Leave Request Form" (DOC 140121B) will be returned to the case manager who will make arrangements for escort and/or transportation, if applicable.

_____ (Initials) For each completed health care appointment in the community, I will submit written documentation using the "Record of Treatment by Community Health Care Provider" form (DOC 140121E). Upon my return from my health care appointment, I will submit this form to my case manager. I understand that this information will be reviewed by an ODOC provider and entered into my medical record in accordance with OP-140106 entitled "Healthcare Record System."

_____ (Initials) I understand that at community corrections centers, I may not purchase, possess, consume or use any over the counter medication that contains alcohol, pseudoephedrine, ephedrine, protonic or prevacid or Vicks/Benzedrix inhalers. I understand that I may only have Zantac (ranitidine) if there is a written order by a physician.

_____ (Initials) I understand that medications with addiction potential, such as specific types of benzodiazepines (for example, Xanax, Valium, Ativan) and specific types of analgesics (for example, oxycodone, hydrocodone) may not be permitted on my facility even though it has been prescribed for me by a community provider.

_____ (Initials) I understand that all prescribed medications must be submitted to staff prior to taking any of the medication to allow staff to log the medication and provide direction. I understand that my facility will make a determination regarding what medication must be locked at the control desk and what medication I may keep in my room. I agree to keep all medication in the original container and if approved to keep the medication in my room, I agree to keep it locked in my locker.

_____ (Initials) I understand that at community corrections centers, in the event that Oklahoma Department of Corrections medical personnel determine that I require emergency care, such care will be provided as specified in OP-140121 entitled "Outside Providers for Health Care Management", Section II. item A.

_____ (Initials) I understand that an important part of my reentry planning is to develop a plan providing for my own health care needs. If I elect to provide for my own medical care and later determine I am unable to continue to do so, I will notify the facility head in writing of my need to access medical services through the Oklahoma Department of Corrections.

_____ (Initials) I understand that if I fail to abide by an approved itinerary for any health care visit, fail to submit any prescribed medication to the staff immediately upon receipt, do not submit a written record of the visit, or do not comply with the limits of the approved medication dosage or submit a positive UA test, I may receive disciplinary action.

Inmate Name: _____ODOC #:_____ Date: _____

Inmate Signature: _____Facility:_____

Witness Name: _____ Title: _____ Date: _____