Medication Renewal for Non-Chronic Clinic Medication

Any inmate not seen for greater than **6 months** he/she will need to be schedule with the provider prior to any refills. Medications that are requested but not listed in the medication list should be scheduled a visit with the healthcare provider first.

Allergies: ______________________________

Original indication for medication? ______________________________

Current Problems: ______________________________

Current medications: ______________________________

1. What is the reason for the request of additional medication? ______________________________
2. Has the inmate experienced any new or worsening symptoms? ❑ Yes ❑ No If "Yes" State: ____________
   ____
3. Does the inmate feel the medication(s) is working as prescribed? ❑ Yes ❑ No
4. Does the inmate experience any side effects from taking the medication? ❑ Yes ❑ No If "Yes" state: __________
   ____
5. Has the inmate missed taking any of his/her medication? (check eMAR) ❑ Yes ❑ No How many times per month has the inmate missed taking the medication? ❑ 1 – 5 times ❑ 6 – 10 ❑ greater than 10
6. What is the inmate's reason for the missed doses? ______________________________
7. If the medication is KOP and had refills, is there documentation that the inmate requested and received a refill on his/her medication every month? ❑ Yes ❑ No If "No" state the number of months the inmate did not request or receive a refill of their medication: ______________________________
8. What is the inmate's reason for the not refilling the medication? (check eMAR) ______________________________
   ____
9. Is the medication available for purchase in the canteen? ❑ Yes ❑ No Is inmate indigent? ❑ Yes ❑ No
10. Date of last provider visit: ____________________
11. Has the inmate "No Showed" for any scheduled appointments since last provider visit? ❑ Yes ❑ No If "Yes" number of appointments "No Showed": ______________________________

11\. Is the inmate adherent to his/her treatment plan? ❑ Yes ❑ No

Progress Note: ______________________________

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Assign the Nurse Protocol to provider for review and determination on renewing the medication.

Healthcare Provider Signature/Credentials: ____________________ **Date:** __________ **Time:** ________

RN/LPN Signature/Credentials: ____________________ **Date:** __________ **Time:** ________

Inmate Name
(Last, First)

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