

**Oklahoma Department of Corrections**  
**Case Manager Review/Medical Treatment Evaluation**

The inmate listed below is being evaluated for medical treatment involving potentially dangerous medications. In order to determine qualification for this treatment, the following information is needed by medical services. Please complete this form and forward it to the medical services unit within 2 weeks.

Date received at A/R \_\_\_\_\_

Sentence \_\_\_\_\_

Earliest expected parole or discharge date \_\_\_\_\_

Required substance abuse treatment?     Yes     No

Check all that apply:

- Inmate is enrolled in substance abuse treatment
- Inmate has completed substance abuse treatment
- Inmate has refused substance abuse treatment

Confirmed alcohol or drug use while incarcerated (with dates):

Misconducts documented during the past 3 calendar years (with dates):

\_\_\_\_\_  
Case Manager Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Inmate Name  
(Last, First)

\_\_\_\_\_  
DOC #