A-08.6 Attachment B Effective: 3/7/2017 Reviewed: 07/2021
TDCJ-Texas Correctional Office on Inmates with Medical or Mental Impairments
MEDICALLY RECOMMENDED INTENSIVE SUPERVISION MEDICAL SUMMARY

Patient Name: <tag> TDCJ# <tag> DOB: <tag> Age: <tag> Race <tag> Gender <tag>

Date/Time:	<tag>	Provider:	<tag name of provider completing order>
Facility:	<tag>	Previous MRIS Summary date:	(type in date of most recent MRIS Medical summary)

(A) MIDLEVEL PROVIDERS – PLEASE SEND FOR CO-SIGNATURE BY PHYSICIAN

1. MEDICAL CRITERIA:

A. PERTINENT MEDICAL HISTORY AND CURRENT DIAGNOSES:

B. MOBILITY

Criteria	Check if applicable **(One Only)**
Bed-ridden - Full assistance for transfers and unable to sit in wheelchair	
Bed-ridden - Full assistance for transfers but able to sit in wheelchair	
Bed-ridden - Partial assistance for transfers and able to sit in wheelchair	
Wheelchair bound requiring full assistance with transfers	
Wheelchair bound requiring partial assistance with transfers	
Wheelchair bound and independent with transfers	
Ambulatory with assistance (includes assistive devices such as walker, cane, etc)	
Ambulatory without assistance **< 50 feet**	
Ambulatory without assistance **> 50 feet**	

C. ACTIVITIES OF DAILY LIVING

Eating	Check if applicable
Requires full assistance to eat	
Unable to use fork or spoon but eats with hands	
Set up required	
Requires prompting	
Independent	

Patient Name: <tag> TDCJ# <tag> DOB: <tag> Age: <tag> Race <tag> Gender <tag>

Bathing	Check if applicable
Requires full assistance to bathe	
Bathes with limited assistance	
Set up required	
Requires prompting	
Independent	

Dressing	Check if applicable
Requires full assistance to dress	
Dresses with assistance	
Set up required	
Requires prompting	
Independent	

Toileting	Check if applicable
Total dependence (full staff performance)	
Extensive assistance (weight bearing support, full staff performance during part of activity but not all of it)	
Limited assistance (highly involved in activity, requires assist with legs or arms, etc)	
Supervision (oversight, encouragement, or cueing required)	
Set-up assistance only	
Independent	

Medication Administration	Check if applicable
Requires administration	
Requires prompting	
Independent	

D. CURRENT PROCEDURES AND TREATMENT:

Criteria	Check if applicable
Hospice	
Dialysis	
Supplemental Oxygen	
Chronic Ventilator Support	
Tracheostomy Care	
Tube Feeding	

Patient Name: <tag> TDCJ# <tag> DOB: <tag> Age: <tag> Race <tag> Gender <tag>

Infirmary/Skilled Nursing Care	(Please list specific skills required)
Other	(Please explain)

2. IS THIS PATIENT'S CONDITION EXPECTED TO IMPROVE? _____Yes _____No
(Please provide brief summary of anticipated changes in patient's condition):

3. ESTIMATED LIFE EXPECTANCY

	Check if applicable
< 6 Months	
6 Months to 1 Year	
More than 1 Year	

4. PHYSICAL HANDICAPS

	Check if applicable
Totally Blind	
Legally Blind	
Visually Impaired	
Legally Deaf	
Paraplegic – Upper Extremities	
Paraplegic – Lower Extremities	
Hemiplegic	
Quadriplegic	
Amputee or loss of any limbs	Please explain:
Other Physical Handicap(s)	Please explain:

5. ADDITIONAL COMMENTS: