CORRECTIONAL MANAGED CARE
INTAKE HISTORY AND HEALTH SCREENING

I. IDENTIFICATION **DATE:** _____

NAME: _____ **OCCUPATION:** _____ **EDUCATION:** _____

DOB: _____ **COUNTY:** _____ **TEXAS UNIFORM HEALTH STATUS UPDATE RECEIVED: Y___ N___**

PREVIOUS TDCJ #(s): _____ **DOI:** _____

Patient Language:	**Name of interpreter, if required:**

TO BE COMPLETED BY THE OFFENDER / UAP / NURSE

II. FAMILY HISTORY					
1. Blood disease (sickle cell anemia, hemophilia)	YES	NO	4. Heart Disease	YES	NO
2. Cancer	YES	NO	5. High Blood Pressure	YES	NO
3. Diabetes	YES	NO	6. Tuberculosis	YES	NO
III. PERSONAL HISTORY					
1. Asthma/Emphysema	YES	NO	13. Heart Disease/Angina	YES	NO
2. Back Injury	YES	NO	14. High Blood Pressure	YES	NO
3. Blood Disease (sickle cell anemia, hemophilia)	YES	NO	15. Intravenous Drug Abuse	YES	NO
4. Cancer	YES	NO	16. Kidney Disease	YES	NO
5. Cavities	YES	NO	17. Liver Disease	YES	NO
6. Depression/Suicide Attempt	YES	NO	18. Mental Illness	YES	NO
7. Diabetes	YES	NO	19. Non Intravenous Drug Abuse/Alcoholism	YES	NO
8. Drug/ Food Allergies	YES	NO	20. Peptic Ulcers	YES	NO
9. Epilepsy/Seizures	YES	NO	21. Smoker	YES	NO
10. Glasses/Hearing Aid	YES	NO	22. Tetanus Immunization Date	YES	NO
11. Gum disease	YES	NO	23. Unprotected Sex with Multiple Partners?	YES	NO
12. Head Injury	YES	NO	24. Other:		
IV. OBSTETRICS / GYNECOLOGICAL HX					
1. Date of last menstrual period:			4. Date of last pap smear:		
2. Number of pregnancies/live births:			5. Date of last mammogram:		
3. History of Problem pregnancy:			6. History of birth control methods (IUD, pills, etc.)		
V. INFECTIOUS DISEASE CONSIDERATIONS (Personal History)			**COMMENTS**		
1. HIV + / AIDS	YES	NO			
Prior HIV test date?					
2. Homosexual /Bisexual Activities	YES	NO			
3. Hepatitis, Type	YES	NO			
4. Were you born between1945-1965?	YES	NO			
5. Tuberculosis	YES	NO			
6. INH Prophylaxis	YES	NO			
7. Sexually Transmitted Infection	YES	NO			
8. Have you ever had a Transplant?	YES	NO			
8B. Have you ever taken transplant medications or are you taking them now?	YES	NO			
8C. If YES, what?					
9. Have you ever received hemodialysis?	YES	NO			
10. Do you have tattoos or body piercings	YES	NO			
11. Did you utilize clotting factors prior to 1987?	YES	NO			
12. Have you shared any personal items lately contaminated with blood such as razors, needles, or toothbrushes?				YES	NO
13. Have you received any blood transfusions prior to 1992?				YES	NO
A	If **YES** to any of the above indicate family member or self, give date and treatment received:				
B	History of hospitalization?	YES	NO		
	Please list the date, hospital & condition				
	Have you experienced any of these symptoms: cough, weakness, weight loss, fevers, night sweats, loss of			YES	NO

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C	appetite or lethargy?		
	If YES, when?		
D	**DRUG & ALCOHOL HISTORY**		
	What illegal drugs have you used?		
	What was the mode(s) of use? (Please circle) Smoking Injection Inhaled Ingested		
	What amount and how often did you use drugs and alcohol?		
	When was the last time you used drugs or alcohol?		

TO BE COMPLETED BY UAP / NURSE

VI. OBSERVATIONS								
A	**APPEARANCE**							
	Hygiene & Appearance	Clean, Neat	YES	NO	Other:			
		Dirty, Sloppy	YES	NO				
	Skin	Cuts	YES	NO	Bruises	YES	NO	
		Sore	YES	NO	Sweating	YES	NO	
		Rashes	YES	NO	Other:			
	Body & Movement	Deformities	YES	NO	Impaired Motor Activity	YES	NO	
		Tremor	YES	NO	Other:			
B	**BEHAVIOR AND MENTAL STATUS**							
	Orientation (ask questions and document response):							
	What is today's date?		What time is it?		What place is this?			
	Speech: ☐ Normal ☐ Loud		☐ Soft		☐ Mumbling	☐ Other:		
	Attitude: ☐ Appropriate ☐ Laughing		☐ Crying		☐ Cursing	☐ Quiet ☐ Other:		
C	**THOUGHT CONTENT (Please circle YES or NO)**							
	Are you having current thoughts about suicide or self-injury?					YES	NO	
	Do you see or hear things that others do not see or hear?					YES	NO	
	Do you have any special powers or abilities?					YES	NO	
	Do you receive personal messages from the tv or radio?					YES	NO	
	Do you have any phobias or excessive fears?					YES	NO	
D	**ORGAN AND TISSUE DONOR**							
	Do you wish to be an organ/tissue donor?					YES	NO	
	If YES, complete the Uniform Donor Card (CMC Policy E-31.2 Att. A)							
E	**CURRENT COMPLAINTS**							
	Do you have any current medical, mental health, or dental complaints?					YES	NO	
	If YES, what?							
F	**EDUCATION: ACCESS TO HEALTH CARE SERVICES, CO-PAYMENT, and GRIEVANCE SYSTEM**							
	Offender given the HSA-34 & informed on how to access health care services, co-payment, & grievance process?					YES	NO	

TO BE COMPLETED BY NURSE ONLY

VII. MEDICATIONS						
Are you presently taking or supposed to be taking prescribed medications?					YES	NO
If YES, refer to HSM-13, Intake Medication Form on page 5.						
VIII. IS THE OFFENDER TAKING ANY MEDICATIONS ASSOCIATED WITH HEAT STRESS?						
1. Anticonvulsants			Desipramine (Norpramin)		YES	NO
Topiramate (Topamax)	YES	NO	Doxepin (Sinequan)		YES	NO
2. Anticholinergics			Imiprmine (Tofranil)		YES	NO
Benztropine (Cogentin)	YES	NO	Notriptylone (Pamelor)		YES	NO
Biperiden (Akineton)	YES	NO	Amitryptyline (Elavil)		YES	NO
Hyoscyamine (Levbid)	YES	NO	**6. Antimanic**			
Oxybutynin (Ditropan)	YES	NO	Lithium carbonate (Eskalith)		YES	NO
Trihexyphenidyl (Artane)	YES	NO	**7. Beta Blockers**			
3. Antihistamines			Atenolol (Tenormin)		YES	NO
Cyproheptadine (Periactin)	YES	NO	Metoprolol (Lopressor)		YES	NO

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Diphenhydramine (Benadryl)	YES	NO	Propranolol (Inderal)	YES	NO
Hydroxyzine (Atarax)	YES	NO	Carvedilol (Coreg)	YES	NO
Promethazine (Phenergan)	YES	NO	**8. Calcium Channel Blockers**		
4. Antipsychotics			Amlodipine (Norvasc)	YES	NO
ALL	YES	NO	**9. Diuretics**		
5. Antidepressants			Furosemide (Lasix)	YES	NO
Clomipramine (Anafranil)	YES	NO	Hydrochlorothiazide	YES	NO
Have you ever had withdrawal or seizures when you stopped using drugs or alcohol?				YES	NO
If you injected drugs, did you share needles, syringes, or intranasal devices				YES	NO
IX. COMMON COMORBIDITIES THAT MAY AFFECT HEAT TOLERANCE					
1. Cardiovascular Disease	YES	NO	7. Seizure Disorder	YES	NO
2. Cirrhosis of the liver	YES	NO	8. Rheumatic Disease	YES	NO
3. Chronic Obstructive Pulmonary Disease/Asthma	YES	NO	9. Sweat gland dysfunction	YES	NO
4. Cystic Fibrosis	YES	NO	10. Thyroid dysfunction	YES	NO
5. Diabetes	YES	NO	11. Age >65	YES	NO
6. Psychiatric conditions	YES	NO			

X. DEVICES (check all applicable & contact as directed)

Allowed in General Population (issue pass and/or schedule for routine care if applicable)		**Contact Provider**		**N/A**
	Automatic Implantable Cardioverter-Defibrillator (AICD)		Insulin Pump	
	BIPAP or CPAP		LifeVest (Wearable Automatic Defibrillator)	
	Cardiac Pacemaker		Pain Pump (External)	
	Helmet for patients with head injuries/seizures		Medication:_____	
	Holter Monitor		Replenishment Frequency: _____	
	Implantable Cardiac Loop Recorder		Pain Pump (Implanted)	
	Ostomy (self-care)		Medication: _____	
	PICC Line		Replenishment Frequency: _____	
	Port-a-Cath		Drain (excluding foley catheter)	
	Saline Lock		External Fixator	
	Suprapubic Catheter (Established)		IV Antibiotics (more than TID)	
	Tracheostomy (Established)		Nephrostomy Tube	
Contact TDCJ Health Services Liaison (HSL)	**N/A**		Ostomy (New)	
	AV Fistula or Graft		Oxygen	
	IV Antibiotics (up to TID)		Peg Tube (new or continuous feeding)	
	Peg Tube (self-care)		Subclavian	
	Permcath (dialysis catheter)		Suprapubic Catheter (New)	
	TDCJ – HSL Notified _____ **Time:** _____		Total Parenteral Nutrition (TPN)	
			Tracheostomy (New)	
			TENS Unit	

Name of Provider Notified	**Time:**
Provider Orders:	
Orders obtained and read back / verified by: (Name)	

XI. DISPOSITION

Routine referral to (circle one):	Dental	Medical	Mental Health
Immediate Referral to (circle one):	Dental	Medical	Mental Health
Release to general population	YES	NO	

Offender's Signature: **Date:**

Screener's Signature: **Date:**

Nurse's Signature: **Date:**

Intake Medication Form

NAME: _____ **Date/Time:** _____

TDCJ #: _____ **DOB:** _____ **UNIT NAME:** _____

Allergies:

ANTIBIOTICS	**IDDM**	**PSYCH ANTIMANICS**
Sulfamethoxizole/Trimethoprim DS 1 tab PO twice daily x days	Insulin NPH units SQ QAM	Lithium mg PO x daily
	Insulin NPH units SQ QPM	**PSYCH NON-FORM MEDS (30 day max)**
ASTHMA / COPD	Insulin R units SQ QAM	
Albuterol INH 2 puffs x daily PRN KOP	Insulin R units SQ QPM	
Fluticasone 110 MCG HFA _____puff(s) twice daily	Insulin R per sliding scale SQ twice daily†	Bupropion (circle – IR / SR / XL)_____mg PO x daily
ANTICOAGULANT/PLATELETS	**NIDDM**	Buspirone mg PO twice daily
EC ASA 81 mg PO once daily	Glipizide mg PO x daily	
Clopidogrel 75mg PO once daily **prior auth**	Metformin mg PO x daily	Gabapentin mg PO x daily
CAD/CHF	**PAIN MEDICATIONS**	Mirtazapine mg PO QPM
Digoxin mg PO once daily	Tylenol mg PO x daily x days	Paroxetine mg PO once daily
Isosorbide Mononitrate mg PO once daily	Ibuprofen mg PO x daily x days	Quetiapine mg QPM
Nitroglycerin 0.4 mg sublingual as directed	Naproxen mg PO x daily x days	
DIURETICS	**PSYCH ANTICHOLINERGIC**	**SEIZURE (or PSYCH ANTIMANIC)**
Furosemide mg PO x daily	Benztropine mg PO QPM	Divalproex EC mg PO twice daily
Hydrochlorothiazide mg PO once daily	Diphenhydramine mg PO x daily	Phenytoin mg PO x daily
GERD	**PSYCH ANTIDEPRESSANTS**	Levetiracetam mg PO x daily
Ranitidine mg PO x daily	Citalopram mg PO once daily	Carbamazepine mg PO x daily
Omeprazole mg PO x daily	Fluoxetine mg PO once daily	**THYROID**
HYPERLIPIDEMIA	Duloxetine mg PO once daily	Levothyroxine mcg PO once daily
Atorvastatin_____mg PO once daily	Sertraline mg PO once daily	**TUBERCULOSIS**
Pravastatin_____mg PO once daily	Trazodone mg PO QPM	Pyridoxine HCL 50 mg: 2 tab (100 mg) 2x per week
HYPERTENSION	Venlafaxine XR mg PO once daily	Isoniazid 300mg: 3 tabs (900 mg) 2x per week
Amlodipine mg PO once daily	**PSYCH ANTIPSYCHOTIC**	**UNLISTED MEDS**
Atenolol mg PO once daily	Chlorpromazine mg PO QPM	†Provide sliding scale directions below if ordered
Carvedilol mg PO twice daily	Fluphenazine mg PO QPM	
Hydralazine mg PO x daily	Haloperidol mg PO QPM	
Lisinopril mg PO once daily	Risperidone mg PO QPM	
Metoprolol mg PO twice daily	Ziprasidone mg PO twice daily	
Terazosin mg PO QPM	Apiprazole mg PO once daily	

HIV ANTIRETROVIRALS		
Abacavir (Ziagen) 300 mg: 2 tabs (600 mg) PO once daily	Etravirine (Intelence) 100 mg: 2 tabs (200 mg) PO twice daily	Ritonavir (Norvir) 100 mg: 1 tab (100 mg) PO twice daily
Atazanavir (Reyataz) 200 mg: 2 caps (400 mg) PO once daily	Fosamprenavir (Lexiva) 700 mg: 2 tabs (1400mg) PO once daily *[with ritonavir 100 or 200 mg daily]*	Tenofovir (Viread) 300 mg: 1 tab (300 mg) PO once daily
Atazanavir (Reyataz) 300 mg: 1 cap (300 mg) PO once daily *[with ritonavir 100 mg daily]*	Lamivudine (Epivir) 300 mg: 1 tab (300 mg) PO once daily	Zidovudine (Retrovir) 300 mg: 1 tabs (300 mg) PO twice daily
Darunavir (Prezista) 800 mg: 1 tab (800 mg) PO once daily *[with ritonavir 100 mg daily]*	Lopinavir/ritonavir (Kaletra) 200/50 mg: 4 tabs (800/200 mg) PO once daily	
Darunavir (Prezista) 600 mg: 1 tab (600 mg) PO twice daily *[with ritonavir 100 mg twice daily]*	Nelfinavir (Viracept) 625 mg: 2 tabs (1250 mg) PO twice daily	
Dolutegravir (Tivicay) 50 mg: 1 tab (50 mg) PO once daily	Raltegravir (Isentress) 400 mg: 1 tab (400 mg) PO twice daily	Azithromycin 600mg: 2 tabs (1200 mg) once weekly
Efavirenz (Sustiva) 600 mg: 1 tab (600 mg) PO once daily	Rilpivirine (Edurant) 25 mg: 1 tab (25 mg) PO once daily **prior auth**	Dapsone 100 mg: 1 tab (100 mg) PO once daily
Elvitegravir/cobicistat/tenofovir/emtricitabine (Genvoya): 1 tab PO once daily **prior auth**	Ritonavir (Norvir) 100 mg: 1 tab (100 mg) PO once daily	Sulfamethox/Trimeth DS: 1 DS tab daily

Provider Signature: _____ **Date:** _____

VO: _____ **Date:** _____ **RBVO /TO: Yes or No Date:** _____