OKLAHOMA DEPARTMENT OF CORRECTIONS
MEDICAL TRANSFER SUMMARY

TRANSFERRING FACILITY

Transferred From: _____ Transferred to: _____ Time: _____ AM PM Date: _____/_____/_____

Allergies (Drug & Food): _____ Dietary Requirement**:** _____

Current Acute Condition/Problem: ☐Yes ☐ No If "Yes" describe _____

Requires Chronic Illness Management: (Check as applicable/specify date of last evaluation) (4-ACRS-4C-06 b-5)

☐ None ☐ Seizure Disorder _____/_____/_____ ☐ Inf. Disease _____/_____/_____
☐ Cardiovascular _____/_____/_____ ☐ Respiratory _____/_____/_____ ☐ COPD _____/_____/_____
☐ Diabetes _____/_____/_____ ☐ CAD _____/_____/_____ ☐ Other: _____

Current Medication(s): ☐ None

Name of Drug (4-4414 b- 4)	**Dosage/Route**	**Frequency**	**Medication Sent with Patient**
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

(Continuation of medications on back)

Orthoses/Prostheses: ☐ None ☐ Braces ☐ Shoe Inserts ☐ Hand/Leg Splints ☐ Limbs ☐ Teeth ☐ Heart Valve ☐ Artificial Eye
Aids of Impairment: ☐ None ☐ Glasses ☐ Walker ☐ Wheelchair ☐ Hearing Aid(s)
Impairments: ☐ None ☐ Mental ☐ Speech ☐ Hearing ☐ Vision ☐ Sensation
Activity Limitation: ☐ None ☐ Moderate ☐ Severe

Specialty Referrals/Pending Appointments: ☐None Date**:** ____/____/____ Time: _____ AM PM Location: _____
(Enter change of facility on Medsyngery)

Pending Laboratory/ X-rays: ☐ None Date: _____**/**_____**/**_____ Time: _____ AM PM Location: _____

Mental Health Concerns: (ACRS-4C-06 b-3) ☐ No ☐ Yes,

Explain_____
_____

Date of next mental health appointment: _____/_____/_____

Date of Last: Physical Exam ____/____/____ HIV ____/____/_____ Results: _____

TB Screening/PPD ____/____/____ Results: _____ TB Med. Initiated ____/____/____ X-ray sent with inmate: ☐ Yes ☐ No ☐ N/A (4-4414, b-5)

Suitable for Transport: (4-4414 b-3) ☐ Without Restriction ☐ With Restrictions Describe: _____

Current HealthSummary: (4-ACRS-4C-06 b-3, 5) _____
_____
_____

_____ _____/_____/_____
Qualified Healthcare Professional Signature/Title **Date**

RECEIVING FACILITY

Received By: _____ Received From: _____ Time: _____ AM PM Date: _____/_____/_____

Medical Chart Review Completed (pending appointments, labs, x-rays, chronic care, current PE): ☐ Yes ☐ No

_____ _____/_____/_____
Health Care Provider/RN/LPN **Date**

Inmate's Name: **DOC #**
(Last, First)

Front

Current Medication(s) Continue: **Name of Drug**	**Dosage/Route**	**Frequency**	**Medication Sent with Patient**
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No