OKLAHOMA DEPARTMENT OF CORRECTIONS

ACTIVITY/HOUSING SUMMARY

HOUSING ASSIGNMENT RECOMMENDATIONS (Justification for special assignments must be documented by medical necessity.)

Basic Housing (check all that apply)

☐ No restrictions
☐ No Halfway House - BRITTLE INSULIN DEPENDENT DIABETICS ARE RESTRICTED
☐ Requires facility with 24/7 medical staff
☐ Requires infirmary care
☐ No county jail placement
☐ Restricted to current facility
☐ Requires daily medical supervised pill line
☐ Requires on-site medical care (institution and community only)
☐ Pregnant

Bunk Assignment

☐ No restrictions
☐ Lower bunk

Quad Assignment

☐ No restrictions
☐ Ground floor
☐ Handicap accommodations

PHYSICAL CAPABILITY (All sections scored over 1 require explanation on PE or progress note)

<table>
<thead>
<tr>
<th>UPPER EXTREMITIES</th>
<th>Score</th>
<th>LOWER EXTREMITIES</th>
<th>Score</th>
<th>Eyes</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>1</td>
<td>Normal</td>
<td>1</td>
<td>Normal</td>
<td>0</td>
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<tr>
<td>Mild functional loss</td>
<td>2</td>
<td>Mild functional loss</td>
<td>2</td>
<td>&lt; 20/40 with or without</td>
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<tr>
<td>Moderate functional loss</td>
<td>3</td>
<td>Moderate functional loss</td>
<td>3</td>
<td>Legally blind</td>
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<tr>
<td>Severe restriction</td>
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<td>Severe restriction</td>
<td>4</td>
<td>SCORE</td>
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<table>
<thead>
<tr>
<th>HEARING</th>
<th>Score</th>
<th>ACTIVITY</th>
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<tbody>
<tr>
<td>Normal</td>
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<td>Unrestricted activity</td>
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<tr>
<td>Mild loss of hearing</td>
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<td>Mild restrictions</td>
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<tr>
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<td>Moderate limits</td>
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<tr>
<td>Severe loss of hearing</td>
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<td>Severe limits</td>
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<tr>
<td>Deaf</td>
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<td>Medically Unassigned</td>
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</table>

☐ Read Lips
☐ Signs
☐ Written Communication

GRADE: W __________ (HIGHEST NUMBER FROM SCORING)

IHAP Codes: MA__________ W __________ MH__________ O__________

Based upon medical examination and/or review the inmate is cleared and approved to work in food service:

☐ Yes
☐ No

ACTIVITY RESTRICTIONS (Check all that apply)

Based upon medical examination and/or review the following restrictions apply. Inmates may not remove themselves from these medical restrictions without clinical documentation.

☐ No restriction
☐ Psychiatrically unassigned
☐ Sedentary work only
☐ No walking more than ________________ yards
☐ No lifting over ________________ pounds
☐ No walking on wet or uneven surfaces
☐ No prolonged sitting or standing
☐ No reaching over shoulder
☐ Other restrictions (list) __________________________________________________________________________

Facility Name __________ Review Date __________ Healthcare Provider/RN/LPN______________________________

Facility Name __________ Review Date __________ Healthcare Provider/RN/LPN______________________________

Facility Name __________ Review Date __________ Healthcare Provider/RN/LPN______________________________

IF THE INMATE’S MEDICAL STATUS HAS CHANGED A NEW HOUSING SUMMARY MUST BE COMPLETED.

Inmate Name
(Last, First)

DOC Number

DOC 140113C (11/17)