

### Jail Transport Information

Client Name: \_\_\_\_\_ Client ID: \_\_\_\_\_ Date Admitted: \_\_\_\_\_

Physicians qualified medical personnel signature(s)	Print Name	Date
<i>(Nursing if MD/NP/PA not in PAC please contact MD/NP/PA for verbal order and list name date and time)</i>		

**MEDICAL ASSESSMENT PRIOR TO TRANSFER/TRANSPORT** (To be completed by Registered Nurse)

Vital signs on transport:

Time	Blood Pressure	Pulse	Respirations	Temp	Weight	HT

Allergies: \_\_\_\_\_

Diagnosis: Axis I- \_\_\_\_\_ Axis II- \_\_\_\_\_ Axis III- \_\_\_\_\_ Axis IV- \_\_\_\_\_

Sexual or Physical Abuse History

Pertinent Physical Assessment:

- Cardiovascular ( example: hypertension, : \_\_\_\_\_
- Integumentary ( wound care: \_\_\_\_\_  Immune System: \_\_\_\_\_
- Respiratory (asthma, O2, sleep apnea: \_\_\_\_\_  Muscular System: \_\_\_\_\_
- Nervous System (seizures; \_\_\_\_\_  Skeletal \_\_\_\_\_
- Digestive System: \_\_\_\_\_  Excretory System \_\_\_\_\_
- Reproductive System \_\_\_\_\_
- Other \_\_\_\_\_

Reason for Transport to jail: \_\_\_\_\_

The following records are **required** to be faxed to receiving jail: *If records are not sent that are required please indicate why not sent: (example N/A)*

- Laboratory Reports
- History Physical
- Treatment Plan (for inpatients)
- Medication List
- Discharge summary
- Medication Lists for prior 7 days (as appropriate)
- Face Sheet
- Radiology Reports
- Progress Notes
- Physician orders in effect
- Consult Report(s)
- Title 36 (as appropriate)
- Other forms: \_\_\_\_\_

Faxed Date: \_\_\_\_\_ Time: \_\_\_\_\_ Name of jail staff receiving fax: \_\_\_\_\_

\*Report called to receiving facility RN: Name: \_\_\_\_\_ Time: \_\_\_\_\_

If report is not given to nurse: *please give reason* : \_\_\_\_\_

RECEIVING POLICE OFFICER SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_ TIME \_\_\_\_\_

RN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_ TIME \_\_\_\_\_

Please contact nursing staff at (phone number) \_\_\_\_\_ if any further information is needed

Before release please contact Clinical Liaison/Case Management:

Clinical Case/Case Manager: \_\_\_\_\_ Phone Number: \_\_\_\_\_

If unavailable please contact **CM Supervisor**: \_\_\_\_\_