Department of Corrections
WASHINGTON STATE

SELF-WELLNESS CHECK

Instructions: To be completed by the segregated individual and Shift Commander **immediately** upon an after-hours arrival to the Secured Housing Unit (SHU) in a stand-alone minimum facility and **daily** on weekends and holidays.
Additional information may be written on back, if needed.

NAME (Last, First):	DOC NUMBER:	FACILITY:
RECEIVED FROM:	DATE:	TIME:

PATIENT TO COMPLETE THIS SECTION

Check all your current problems:

- ☐ Diabetes
- ☐ Seizures
- ☐ Rash
- ☐ Chest pain
- ☐ Asthma – Are you short of breath? ☐ No ☐ Yes
- ☐ Nausea and vomiting
- ☐ Open wounds or sores
- ☐ Thoughts of suicide or self-harm
- ☐ Pregnant (Females Only)
- ☐ Pain – Explain below

_____

_____

- ☐ Medication allergy (list below)

_____

_____

- ☐ Dietary issues (list below)

_____

_____

- ☐ I want to see a mental health provider

I am taking the following medications (list both OTC and prescription, continue on back if needed)

_____

_____

_____

- ☐ I have no medical, dental, or mental health problems

_____
PATIENT SIGNATURE

SHIFT COMMANDER OBSERVATION

Check all that apply:

- ☐ Not Conscious*****
- ☐ Difficulty speaking or forming words*****

***Call 911 and render first-responder aid**

- ☐ Confused or disoriented
- ☐ Shaking/sweating/nausea/vomiting/diarrhea
- ☐ Extremely abnormal behavior and/or conduct
- ☐ Behavioral changes after admission
- ☐ Threats of self-harm
- ☐ Body or bone deformities
- ☐ Injuries/bruising
- ☐ Difficulties with walking or standing
- ☐ Wheelchair
- ☐ Crutches
- ☐ Refusing consecutive meals – How many? _____

After completing the form, if there are any health concerns indicated by the individual or if the shift commander has any concerns about the individual's health, call the MOD immediately to notify him/her that the individual is in the SHU and to receive medical care instructions.

Circle those medications which have been identified by the MOD to be returned to individual.

☐ No meds to be returned

_____ _____
MOD NAME TIME

By signing this form, I am acknowledging that I have observed and spoken to this individual as part of the daily wellness check requirement.

_____
SHIFT COMMANDER SIGNATURE

Send completed form to Medical for filing in the Health Record

State law and/or federal regulations prohibit disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.

SELF-WELLNESS CHECK

NAME (Last, First):	DOC NUMBER:	DATE:

PATIENT ADDITIONAL INFORMATION	SHIFT COMMANDER ADDITIONAL INFORMATION

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