Department of Corrections
WASHINGTON STATE

PATIENT I.D. DATA:
(name, DOC #, birthdate)

HEALTH STATUS REPORT

FACILITY	LIVING UNIT	DATE

RESTRICTIONS/LIMITATIONS (Check as applicable – Use Comments section for additional clarification)

A. Housing Restrictions/Limitations

	Expiration		Expiration
☐ Single Cell		☐ Limited Stairs – Specify	
☐ No Upper Bunk		☐ No Stairs, may do limited steps	
☐ Lower Tier		☐ No Steps	
☐ Elevator			

B. Assignment/Work/Transportation/Activity

	Expiration		Expiration
☐ Bed rest		☐ No Work on Scaffolding/Ladders	
☐ Lay In		☐ No Uneven Ground or Steep Hills	
☐ Meals In		☐ No DNR (Dept. of Natural Resources)	
☐ Restricted to Living Area/Unit		☐ No Food Service	
☐ Kitchen Clearance		☐ Work-hour Adjustment – Specify	
☐ Release for Work		☐ Work Restrictions (other) – Specify	
☐ Restrict Lifting: _____ pounds		☐ No Restrictions/Limitations/Holds	
☐ Restrict Standing: _____ minutes		☐ Restrictions – Specify	
☐ Restrict Sitting: _____ minutes		☐ Special Requirements – Specify	
☐ No Vigorous Activity		☐ Other Pass – Specify	
☐ No Machine Operation			

C. Durable Medical Equipment

	Expiration		Expiration
☐ Ace Wrap		☐ Hearing Aid	
☐ Brace – Specify		☐ Ice	
☐ Cane – ID#:		☐ Orthotics – Specify	
☐ Cast/Splint – Specify		☐ Prosthetics – Specify	
☐ Cotton Blanket x		☐ Shower Chair – ID#:	
☐ Crutches x – ID#:		☐ Special Shoes	
☐ Dressing/Bandages – Specify		☐ Walker – ID#:	
☐ Electric Shaver		☐ Hot-Water Bottle	
☐ Extra Pillow(s) x		☐ Wheelchair – ID#:	
☐ Glucometer/Sharps Container/ Lancets/Test Strips		☐ Wheelchair Pusher Required ☐ Wedge	

D. Other

	Expiration		Expiration
☐ Metal Implant(s) – Specify		☐ See Comments (3)	

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E. Dietary

	Expiration		Expiration
☐ Blue Snack		☐ Hard Boiled Eggs x 2	
☐ Breakfast ☐ Lunch ☐ Dinner		☐ Breakfast ☐ Lunch ☐ Dinner	
☐ Blue Snack w/Milk (females)		☐ Lighter Fare Diet	
☐ Breakfast ☐ Lunch ☐ Dinner		☐ Low K+ Diet	
☐ Blue Snack x 2		☐ Mainline Alternative	
☐ Breakfast ☐ Lunch ☐ Dinner		☐ Mechanical Soft Diet	
☐ Bran		☐ Milk	
☐ Clear Liquid Diet		☐ Breakfast ☐ Lunch ☐ Dinner	
☐ Crackers		☐ Milk x 2	
☐ Breakfast ☐ Lunch ☐ Dinner		☐ Breakfast ☐ Lunch ☐ Dinner	
☐ Ensure or Boost Liquid Supplement		☐ No Gluten	
☐ Fortified Beverage Packet		☐ No Peanut Diet	
☐ Full Liquid Diet		☐ No Tomato Diet	
☐ Green Snack		☐ Orange Snack	
☐ Breakfast ☐ Lunch ☐ Dinner		☐ Breakfast ☐ Lunch ☐ Dinner	
☐ Green Snack x 2		☐ Orange Snack x 2	
☐ Breakfast ☐ Lunch ☐ Dinner		☐ Breakfast ☐ Lunch ☐ Dinner	
☐ Green Snack/No Gluten		☐ Puree Diet	
☐ Breakfast ☐ Lunch ☐ Dinner		☐ Yellow Snack	
☐ Green Snack/No Gluten x 2		☐ Breakfast ☐ Lunch ☐ Dinner	
☐ Breakfast ☐ Lunch ☐ Dinner		☐ Yellow Snack x 2	
☐ Hard Boiled Eggs		☐ Breakfast ☐ Lunch ☐ Dinner	
☐ Breakfast ☐ Lunch ☐ Dinner		☐ Other – Specify diet	

ALLERGIES

☐ Bee Stings ☐ Latex ☐ Peanuts ☐ Other – Specify

COMMENTS (e.g., **equipment issue date** if different than date of HSR, specifications, special instructions)

HEALTH SERVICES PROVIDER (Stamp/Print and Initial)	DATE	ALTERNATE HEALTH SERVICES STAFF (Stamp/Print and Initial)	DATE

DISTRIBUTION: ☐ Health Record (Original) ☐ Individual ☐ Counselor/CUS ☐ Unit Sergeant ☐ Shift Sergeant ☐ Dietary ☐ Supply Tech ☐ Laundry/Clothing ☐ Education ☐ Recreation ☐ Control ☐ Correctional Industries ☐ Other: ☐ Other: