Department of Corrections
WASHINGTON STATE

PATIENT I.D. DATA:
(Name, DOC#, DOB)

PRIMARY ENCOUNTER REPORT

DATE	TIME	FACILITY	UNIT (optional)

Subjective Complaint/Objective Findings/Assessment/Evaluation:

Diagnosis/Plan/Rx: (Diagnosis required for medication orders. Allergies required for new medication orders.)

☐ Risks/benefits of recommended intervention explained; patient consents.

Name and Title of Employee/Contract Staff Performing Encounter:	Signature:

DOC 320.255 DOC 320.260 DOC 410.430 DOC 420.250 DOC 420.255
DOC 420.312 DOC 610.010 DOC 610.025 DOC 610.600 DOC 670.020 DOC 890.600