Department of Corrections
WASHINGTON STATE

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

TRANSFER SUMMARY FOR WORK RELEASE

Instructions: To be completed for all patient transfers to work release facilities.

DATE OF TRANSFER	TRANSFERRING FACILITY	INTERIM FACILITY	TRANSFER TO

ALLERGIES (meds or food) ☐ **None**

HEPATITIS / TETANUS ☐ **None**

Hepatitis A Series (dates given)**:**
1)_____ 2)_____
Next Due: _____

Hepatitis B or A/B Series (dates given)**:**
1)_____ 2)_____
3) _____ Next Due:_____

Date of last tetanus: _____

PPD / TB

Date PPD read: _____
Results: _____ millimeters
Symptom screen date: _____
Results: _____
Chest x-ray date: _____
Results: _____
Completed treatment (INH): Yes / No
Date: _____

☐ No meds ☐ MAR copy attached ☐ Keep on person meds* ☐ En route meds** (attach copy of form to meds)

***MEDICATIONS TO BE KEPT ON PERSON DURING TRANSPORT**

☐ Inhaler ☐ Nitro ☐ Other: _____

****EN ROUTE MEDICATIONS (to be distributed by officers during transport)**

☐ Meds received Patient signature: _____

Specific Needs at Time of Transfer:

☐ No special needs ☐ Walker, Cane, Crutches ☐ Wheelchair ☐ Lower bunk
☐ Walk less than two blocks ☐ No stairs
☐ Special diet: _____
☐ Other: _____
(GLASSES, CONTACTS, HEARING AID, PROSTHETICS, DENTURES, PARTIALS, ETC.)

Ongoing medical services needed (include type, frequency, and if a community referral has been made):

_____

_____

Routine medications: ☐ Requires ongoing medication ☐ May become unstable if not compliant with medication

Work limitations: _____

_____

Accommodations needed for living space: _____

_____

Other considerations (medically indicated snacks, oxygen, _____

_____

***For further healthcare information, please contact sending facility Health Care Manager.**	COMPLETED BY (stamp/print and signature)	DATE COMPLETED

DISTRIBUTION: WHITE – HEALTH RECORD
CANARY – TRANSPORTING OFFICER (To be delivered to Receiving Facility)