 **BOARDER HEALTH HISTORY SCREENING**

Name:       DOC #:

Birthdate:       Gender: [ ]  Male [ ]  Female [ ]  Other -

Sending jurisdiction:       Receiving facility:

Reason for request: [ ]  Behavior [ ]  Security [ ]  Safety [ ]  Medical [ ]  Mental Health [ ]  Unknown

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| **CURRENT MEDICATIONS**(list below or [ ]  Medication Administration Record (MAR) attached) |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |

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| **ALLERGIES/SENSITIVITIES** (list below or [ ]  MAR attached) |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |

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| **TEST RESULTS** |
| **Test** | **Results/treatment** | **Date** |
| Purified Protein Derivative (PPD) |        mm |       |
| Chest x-ray, if PPD positive | WNL / ABN |       |
| Hepatitis C status | NOT DET / DET |       |
| Hepatitis C treatment completed? | Yes / No |       |
| Hepatitis A | - / + |       |
| Hepatitis B | - / + |       |
| HIV/AIDS | - / + |       |

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| **CONSIDERATIONS** |
| Physical/functional limitations or durable medical equipment required? [ ]  No [ ]  Yes, specify:       |
| Accidents/injuries? [ ]  No [ ]  Yes, specify:       |
| Special housing? [ ]  No [ ]  Yes, specify:       |

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| **MENTAL HEALTH HISTORY** |
| History of self-harm (check all that apply)? [ ]  No [ ]  Yes, last known date:      Specify: [ ]  Suicide attempts, how many?       [ ]  Self-injurious behavior [ ]  Unknown [ ]  Other -       |
| History of suicidal ideation? [ ]  No [ ]  Yes, last known date:       |
| Mental health diagnosis:       |
| Past mental health treatment (check all that apply):[ ]  Psychiatric hospital [ ]  Residential mental health in correctional setting [ ]  Supported housing[ ]  Outpatient treatment [ ]  Involuntary treatment [ ]  None [ ]  Unknown |

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| **HISTORY OF OPERATIONS/ACCIDENTS** |
| **Operation** | **Yes** | **No** | **Date** | **Operation** | **Yes** | **No** | **Date** | **Operation** | **Yes** | **No** | **Date** |
| Hernia | [ ]  | [ ]  |  | Gall bladder | [ ]  | [ ]  |  | Splenectomy | [ ]  | [ ]  |  |
| Back/neck | [ ]  | [ ]  |  | Hysterectomy | [ ]  | [ ]  |  | Abortion/D&C | [ ]  | [ ]  |  |
| Appendix | [ ]  | [ ]  |  | Gunshot wound | [ ]  | [ ]  |  | Hemorrhoid | [ ]  | [ ]  |  |
| Bone/joint fracture | [ ]  | [ ]  |  | Other -       | Other -       |

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| **HISTORY OF DISEASES** |
| **Disease** | **Yes** | **No** | **When** | **Disease** | **Yes** | **No** | **When** | **Disease** | **Yes** | **No** | **When** |
| Tuberculosis | [ ]  | [ ]  |       | High blood pressure | [ ]  | [ ]  |       | Liver disease | [ ]  | [ ]  |       |
| Asthma | [ ]  | [ ]  |       | Heart attack | [ ]  | [ ]  |       | Seizures | [ ]  | [ ]  |       |
| Lung disease | [ ]  | [ ]  |       | Stroke | [ ]  | [ ]  |       | HIV/AIDS | [ ]  | [ ]  |       |
| Diabetes | [ ]  | [ ]  |       | Hernia | [ ]  | [ ]  |       | Arthritis | [ ]  | [ ]  |       |
| Multiple Sclerosis  | [ ]  | [ ]  |       | Bleeding problems | [ ]  | [ ]  |       | Sickle cell disease | [ ]  | [ ]  |       |
| Peptic ulcers | [ ]  | [ ]  |       | Urinary/kidney | [ ]  | [ ]  |       | Mental illness | [ ]  | [ ]  |       |
| Cancer | [ ]  | [ ]  |       | Other -       | Other -       |
| If yes, type/location -       |

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| **OBSTETRICS/GYNECOLOGY HISTORY** (if applicable) |
| [ ]  Pregnant Number of pregnancies:       Number of live births:       Number of miscarriages:       |
| Last breast exam:       Result:       |
| Last mammogram:       Result:       |
| Last pap smear:       Result:       |
| Flushing/menopause:       Other:       |

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| **HISTORY OF TOBACCO/ALCOHOL/DRUG USE AND TREATMENT** |
| Previous substance use disorder treatment? [ ]  No [ ]  Yes, specify:       Dates of treatment:       Outcome:      Positive drug/alcohol tests during incarceration? [ ]  No [ ]  Yes |
| **Substance** | **Yes** | **No** | **Never** | **Date stopped** | **Amount per day** |
| Tobacco | [ ]  | [ ]  | [ ]  |       |       |
| Alcohol | [ ]  | [ ]  | [ ]  |       |       |
| Drug(s) of choice:       | [ ]  | [ ]  | [ ]  |       |       |

Comments:

Please attach the following documents, as applicable, and **fax** to the Nurse Desk at **(360) 586-9060**.

If you have any questions, call the Nurse Desk at **(360) 725-8733**.

[ ]  Chart notes [ ]  MAR [ ]  Intake summary [ ]  Consult notes [ ]  ER notes [ ]  Hospital/clinical/medical notes

Point of contact name Telephone number Date

      

Health care provider’s name Signature Date

**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.**

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