 **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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