



HEALTH SERVICES KITE

This form must be used to request non-emergency healthcare services, except in facilities where kiosks or sign-up sheets are used.

PLEASE PRINT

SUBMISSION OF HEALTH SERVICES REQUEST MAY RESULT IN A CO-PAY

LAST NAME			FIRST NAME	
DOC NUMBER	FACILITY	UNIT/CELL	DATE	TIME
JOB/PROGRAM		JOB/PROGRAM HOURS		DAYS OFF

If you feel you have an actual medical emergency, alert the staff and do not use this form.

TYPE OF REQUEST (check only one box per form)

- ☐ MEDICAL ☐ DENTAL ☐ MENTAL HEALTH ☐ PSYCHIATRY
☐ OPTOMETRY ☐ HEALTH SERVICES REENTRY TEAM ☐ MEDICAL RECORDS
☐ MEDICATION REFILL – List medication(s) with prescription number(s) or place sticker below
☐ MEDICATION FOR SUBSTANCE USE DISORDER ☐ OTHER: _____

REASON FOR REQUEST (list problem or medications needing refill)

PATIENT SIGNATURE

HEALTH SERVICES RESPONSE/ENCOUNTER

This form must be filed if any information is entered below except for: simple prescription refills, finance, non-medical work/bunk change, religious diets, shoes, classification, complaints about staff, non-health services issues

<input type="checkbox"/> Schedule within ____ days/weeks/months	<input type="checkbox"/> Next available sick call	<input type="checkbox"/> No visit required
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RESPONDER signature and stamp (all copies)	DATE and TIME
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Distribution: **WHITE/YELLOW** – Responder, **PINK** – Patient keeps

Distribution upon completion: **WHITE** – Health Record, **YELLOW** – Return to Patient with Response

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.