State of Alaska **Department of Corrections** **Health & Rehabilitation Services**	**Facility** _____ **Name** _____ **DOB** _____ **OBSCIS#:** _____ **Age:** _____ **Sex:** _____ **Booking Date:** _____ **Booking Time:** _____ **807.14A Page 1 of 3** *revised 2/2017*

CRIMINAL BOOKING SCREEN

Use standard precautions when screening all new detainees

PRE-BOOKING SCREEN *Completed prior to booking into DOC custody*

Is the detainee unconscious or unable to be roused with voice or physical stimulation?	YES	NO
Does the detainee have obvious pain, bleeding, signs of trauma or illness suggesting **immediate** need for emergency service?	YES	NO
Exclusive of disability, is the detainee unable to stand and walk with one person offering minimal assistance?	YES	NO

BRAC: Time:

Any YES answer to above questions - notify remanding officer that a written medical discharge note from local hospital is required prior to booking into DOC custody.

Date Time

Completed by:

DETAINEE SEEN AT LOCAL MEDICAL FACILITY PRIOR TO BOOKING? *(If YES, complete the following questions)* YES NO

Sent by DOC? YES NO

Name of Facility _____ Date & Time of Visit _____

Reason for visit & treatment received _____

Condition upon return: Condition stabilized prior to return? YES NO

Written ER note including discharge paperwork obtained and placed in medical record? YES NO

POST-BOOKING OBSERVATION *Completed immediately after booking by medical staff or security staff when no medical staff on duty.*

Are there any obvious physical impairments?	YES	NO
Does the detainee appear to be under the influence of alcohol? Smell of alcohol on breath?	YES	NO
Does the detainee appear to be under the influence of any drug? YES NO Describe:		
*Are there visible signs or symptoms of alcohol or drug withdrawal?	YES	NO
Is there evidence of contagious or infectious health conditions that may spread throughout the institution?	YES	NO

Lice YES/NO Location _____ Rash YES/NO Location _____

*Open or draining wounds? YES/NO Location _____

*Fever	YES	NO	*Chills	YES	NO
*Cough	YES	NO	*Vomiting	YES	NO
*Sore Throat	YES	NO	*Diarrhea	YES	NO

Did detainee arrive with prescribed medications?	YES	NO
*Does detainee report prescribed medications that must be taken prior to medical staff on duty?	YES	NO

Call Provider for all "YES" answers to questions preceded by an asterisk *. Isolate detainee & call provider for all "YES" responses to feeling ill AND reporting symptoms of contagious conditions. (Medical staff initiates Complaint Specific Nursing Protocol.) Document provider contact at bottom of page.

Date Time

Completed by:

SUICIDE RISK FACTORS *Completed immediately after booking by medical staff or security staff when no medical staff on duty.*

Is this your first time in jail?	YES	NO
Are you thinking of killing yourself? *YES response to this question requires immediate suicide precautions & referral to Mental Health.*	YES	NO
Have you ever thought about killing yourself?	YES	NO
Has anyone in your family ever committed suicide?	YES	NO
Have you ever attempted to kill yourself?	YES	NO
If YES, how many times Method?		
When was most recent time?		
Have you experienced a recent significant loss?	YES	NO
Have you ever been diagnosed with depression?	YES	NO
Does detainee appear overly embarrassed, ashamed or guilty about accused crime?	YES	NO

3 or more YES responses require referral to mental health, greater than 5 YES responses also requires immediate suicide precautions.

Date Time

Completed by:

Provider contacted: _____ **Date & Time:** _____

Orders/Directions received: _____

_____ **Signature:** _____

CRIMINAL BOOKING SCREEN

VITAL SIGNS	Temperature:	Pulse:	Respirations:	B/P:	O_2 Sat:	Weight:	BRAC: Date/Time:

ALLERGIES: *(Indicate all allergies)*

HEALTH SCREEN: Do you have any of the following conditions? *(Each question is addressed with every detainee. Circle Yes or No)*

Heart Problems	Y	N	Ortho Condition	Y	N	**STD SCREEN**			**FEMALE ONLY**	**G:**	**P:**
High blood pressure	Y	N	Deformities	Y	N	Venereal Disease:	Y	N	LMP:		
Angina	Y	N	Eye Problems	Y	N	❒AIDS Date: TX:			Are you pregnant?	Y	N
Diabetes *(Circle)* Type I Type II	Y	N	Hearing Problems	Y	N	❒Syphilis Date: TX:			Are cycles regular?	Y	N
									Painful/heavy flow?	Y	N
Seizures/Epilepsy	Y	N	Kidney problems	Y	N	❒Gonorrhea Date: TX:			Recent delivery	Y	N
Asthma	Y	N	Painful urination	Y	N	❒Chlamydia Date: TX:			Vaginal discharge	Y	N
Difficulty breathing	Y	N	Liver disease	Y	N	❒Herpes Date: TX:			Pelvic pain/PID	Y	N
Skin Condition: ☐ Rash	Y	N	Hepatitis *Circle* A B C	Y	N	Discharge, sores or other symptoms:			Birth control method		
☐ Boil			Gastrointestinal	Y	N	Wants HIV test	Y	N	Last taken:		
☐ Lumps			☐ Hernia			General Appearance:			Post-menopausal	Y	N
☐ Itching			☐ Blood in stool						Breast lumps	Y	N
☐ Other			Dental Problems	Y	N				Nipple discharge	Y	N

Are you wearing or do you regularly use contacts, glasses, hearing aid, prosthetics, dentures, crutches, cane or any other medical device? Yes No
Do you have your medical device with you? Yes No
Additional information:

Have you recently been injured? Yes / No *(Please circle)* traffic accident head injury fight other:
Type of injury:

Do you have any other medical conditions we should know about?

Medical treatment prior to incarceration? *List current treatment and recent surgeries.*

Alcohol and Drug Screen

Alcohol use: Type and amount used daily?
Number of drinks last 24 hr? How long ago?

Drug use: Type and amount used daily?
Amount and Time of last dose?

Do you have problems that occur after stopping the use of drugs or alcohol? Y / N
Explain:

History of withdrawal seizures? Y/N

Mini CIWA: *Notify provider of positive findings* ❒ **Detox Protocol Initiated**

☐Nausea & Vomiting ☐Anxiety ☐Auditory Disturbance
☐Tremor ☐Agitation ☐Visual Disturbance
☐Paroxysmal Sweats ☐Tactile Disturbance ☐ Headache
☐Orientation & Clouding of Sensorium:

Tuberculosis Screen

Have you ever been ill with Tuberculosis?	YES	NO
Date: Completed Treatment?	YES	NO
Have you recently been around someone with TB?	YES	NO
Do you currently have:		
• Productive cough for more than two weeks?	YES	NO
• Night sweats?	YES	NO
• Recent unexplained weight loss?	YES	NO
• Coughing up blood?	YES	NO
• Unexplained fatigue?	YES	NO

Date of last PPD if known	PPD Placed: Date & Time	Given by:

REPORTED MEDICATIONS: Has medications with them? YES / NO ❒ ROI sent ❒ Placed in Tamper Proof Envelope #:
Record medication history as reported by detainee. Follow policy 807.05 for handling personal medications brought to facility.

HOUSING ASSIGNMENT OF DETAINEE: ❒ Open Population ❒ Medical Segregation ❒ Detox Cell/Booking ❒Other:

Medical Referral ❒Yes ❒No ❒Chart only
Provider Contacted: Date: Time:

Mental Health Referral ❒Yes ❒No ❒Chart only
Professional Contacted: Date: Time:

Instructed on how to access health care? ❒Yes ❒No
Language Barrier? ❒Yes ❒No Unable to complete screen ❒Yes ❒No

Detainee uncooperative/Unable to complete screen? ❒Yes ❒No
Uncooperative Detainee Protocol initiated? ❒Yes ❒No

Completed by:	Date	Time

CRIMINAL BOOKING SCREEN

BRIEF JAIL MENTAL HEALTH SCREEN

INSTRUCTIONS:

ITEMS 1-6:

Place a check mark in the appropriate column (for "NO" or "YES" response).

If the detainee REFUSES to answer the question or says that he/she DOES NOT KNOW the answer to the question, do not check "NO" or "YES." Instead, in the General Comments section, indicate REFUSED or DON'T KNOW and include information explaining why the detainee did not answer the question.

ITEM 7: This refers to any prescribed medication for any emotional or mental health problems.

ITEM 8: Include any stay of one night or longer. Do NOT include contact with an Emergency Room if it did not lead to an admission to the hospital.

GENERAL COMMENTS COLUMN:

- *As Indicated above, if the detainee REFUSES to answer the question or says that he/she DOES NOT KNOW the answer to the question, do not check "NO" or "YES." Instead, in the General Comments section, indicate REFUSED or DON'T KNOW and include information explaining why the detainee did not answer the question.*
- *All "YES" responses require a note in the General Comments section to document:*
  1. *Information about the detainee that staff feels is relevant and important.*
  2. *Information specifically requested in question*
- *If at any point during administration of the BJMHS the detainee experiences distress, staff should follow the jail's procedure for referral services.*

QUESTIONS	NO	YES	COMMENTS:
1. Do you currently believe that someone can control your mind by putting thoughts in to your head or taking thoughts out of your head?			
2. Do you currently feel that other people know your thoughts and can read your mind?			
3. Have you currently lost or gained as much as two pounds a week for several weeks without even trying?			
4. Have you or your family or friends noticed that you are currently much more active than you usually are?			
5. Do you currently feel like you have to talk or move more slowly than you usually do?			
6. Have you recently few weeks when you felt like you were useless or sinful?			
7. *Are you currently taking any medication prescribed for you by a physician for any emotional or mental health problem?			
8. *Have you ever been in a hospital for emotional or mental health problems?			

Staff Comments/Impressions:

*Have you ever had a significant traumatic brain injury?	YES	NO	
*Have you been diagnosed with fetal alcohol syndrome (FAS)?	YES	NO	

REFERRAL INSTRUCTIONS: ***(All questions preceded by an asterisk * require a Mental Health referral)***

Any detainee answering YES to Item 7 or YES to Item 8 or YES to at least two of Items 1-6 should be referred for further mental health evaluation. If there is any other information or reason why staff feel it is necessary for the detainee to have a mental health evaluation, the detainee should be referred.

- ☐ Yes to item 7; OR
- ☐ Yes to item 8; OR
- ☐ Yes to at least 2 of items 1-6 ; OR
- ☐ If you feel it is necessary for any other reason
- ☐ History of significant traumatic brain injury
- ☐ History of FAS

Mental Health Referral: ❒YES ❒NO ❒Placed on Mental Health Referral Log

Mental Health Professional contacted: **Date & Time:**

Orders/Directions received:

Completed by/Signature: **Date & Time:**