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

TITLE 47 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:	YES	NO
*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: _____

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

TITLE 47 SCREEN

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

ALLERGIES: *(Indicate all allergies)*

Detainee uncooperative/Unable to complete screen? Yes No Placed on cumulative observations? Yes No
Uncooperative Detainee Protocol initiated? Yes No

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? Females only: Are you pregnant? Yes No

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? Yes No Unknown

Orientation: ☐ Person ☐ Place ☐ Time ☐ Disoriented

Thought process: Can form sentence: Yes No
Conversation appropriate: Yes No

Agitation: ☐ Normal activity ☐ Restless ☐ Pacing/Thrashing

Comments:

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

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.

Date	Time	Notes/Observations	Initials
		General appearance:	

Medical Referral ❒Yes ❒No Reason: _____
Provider Contacted: Date: Time:

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

Language Barrier? ❒Yes ❒No

Completed by:	Date	Time
Date & Time of Release:		