



State of Alaska
 Department of Corrections
 Inmate Health

Facility _____
 Name _____
 DOB _____ OBSCIS#: _____ Age: _____ Sex: _____
 Booking Date: _____ Booking Time: _____
 807.14B Page 1 of 2 revised: 11/2010

TITLE 47 SCREEN

Use standard precautions when screening all new detainees

PRE-BOOKING SCREEN <i>Completed prior to booking into DOC custody</i>			
Is the detainee unconscious? Does not respond to voice or touch?	YES	NO	
Does the detainee have obvious pain or bleeding or other symptoms suggesting need for emergency service?	YES	NO	
Are there visible signs of trauma or illness requiring immediate emergency or doctor's care?	YES	NO	
BRAC _____ Time _____ BRAC greater than 300? (<i>BRAC is performed on ALL detainees PRIOR to booking</i>)	YES	NO	
Detainee refuses BRAC and appears significantly intoxicated?	YES	NO	
<i>Any YES answer to above questions - notify remanding officer that written medical clearance from local hospital is required prior to booking into DOC custody.</i>			
Completed by: _____	Date	Time	
DETAINEE SEEN AT LOCAL MEDICAL FACILITY PRIOR TO BOOKING? (<i>If YES, complete the following questions</i>)			
Name of Facility _____ Date & Time of Visit _____	Sent by DOC?	YES	NO
Reason for visit & treatment received _____			
Condition upon return: _____	Condition stabilized prior to return?	YES	NO
	Written Medical Clearance obtained and placed in medical record?	YES	NO
POST-BOOKING OBSERVATION <i>Completed immediately after booking by medical staff or security staff when no medical staff on duty.</i>			
Are there any obvious physical handicaps?	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	
*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
*Cough	YES	NO	*Vomiting
*Sore Throat	YES	NO	*Diarrhea
Is the detainee carrying medication?	YES	NO	
*Does detainee report prescribed medications that must be taken prior to medical staff on duty?	YES	NO	
<i>Call Provider for all "YES" answers to questions preceded by an asterisk *. Isolate prisoner & 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.</i>			
Completed by: _____	Date	Time	
SUICIDE RISK FACTORS <i>Completed immediately after booking by medical staff or security staff when no medical staff on duty.</i>			
Is this your first time in jail?	YES	NO	
Are you thinking of killing yourself? <i>YES response to this question requires immediate suicide precautions & referral to Mental Health.</i>	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 current situation?	YES	NO	
<i>3 or more YES responses require referral to mental health, greater than 5 YES responses also requires immediate suicide precautions.</i>			
Completed by: _____	Date	Time	

Provider contacted: _____	Date & Time: _____
Orders/Directions received: _____	
Signature: _____	

