Reset Form

SUMMARY OF COUNTY JAIL MEDICAL RECORD

State Form 56193 (R2 / 3-20)
DEPARTMENT ON CORRECTION
DIVISION OF HEALTH CARE SERVICES

INSTRUCTIONS: This form must be completed in its entirety by Jail staff and submitted to the Indiana Department of Correction receiving facility in Adobe Acrobat (.pdf) format. Attach additional pages as necessary.

GENERAL INFORMATION

Name of offender *(last, first, middle)*	Date of birth *(month, day, year)*	Gender ☐ Male ☐ Female	DOC number *(if known)*

Alias(es)	County of commitment	Length of time in facility	Cause number

MEDICAL / MENTAL HEALTH HISTORY

Allergies ☐ None ☐ Unknown ☐ Known	If known, list allergies.

Did the offender require detoxification? ☐ Yes ☐ No

SURGICAL HISTORY

CURRENT MEDICATIONS

Medication	Dosage	Targeted Symptoms

CURRENT DIAGNOSES

CURRENT / ONGOING TREATMENTS

INFECTIOUS DISEASE HISTORY

Known TB exposure? ☐ Yes ☐ No	Known positive Purified Protein Derivative (PPD)? ☐ Yes ☐ No	Fever within last twenty-four (24) hours? ☐ Yes ☐ No

Date treatment received, *if applicable (month, day, year)*	Location treatment received, *if applicable*

Medications received, *if applicable*

PREPARED BY:

Signature of staff completing this form	Date signed *(month, day, year)*

Printed name of staff completing this form	Title

DISTRIBUTION: Copy – Offender Records; Copy – Receiving Facility; Copy – Sending County Jail