ADMINISTRATIVE POLICIES AND PROCEDURES State of Tennessee Department of Correction	Index #: 113.30	Page 1 of 11
	Effective Date: February 1, 2022	
	Distribution: A	
	Supersedes: 113.30 (8/1/18) PCN 19-52 (8/1/19)	
Approved by: Lisa Helton		
Subject: ACCESS TO HEALTH CARE		

I. AUTHORITY: TCA 4-3-603 and TCA 4-3-606.

II. PURPOSE: To ensure that all inmates within the physical custody of the Tennessee Department of Correction (TDOC) have access to appropriate levels of health care on a 24-hour a day basis.

III. APPLICATION: Wardens, Superintendents, Health Administrators, health care staff, privately managed facilities, all employees, contractors, visitors, volunteers, and inmates.

IV. DEFINITIONS:

A. Cardiopulmonary Resuscitation (CPR): The combination of artificial respiration and chest compressions designed to restore normal breathing after cardiac arrest.

B. First Aid: Emergency care or treatment given to an ill or injured inmate prior to the arrival of a health care provider or transportation to a hospital.

C. Qualified Clinical Personnel: Personnel who are legally authorized by licensure, registration, or certification to perform direct or supportive health, mental health care or substance use services and whose primary responsibility it is to provide clinical services to inmates in the custody of the Tennessee Department of Correction (TDOC). Examples of qualified clinical personnel are physicians, dentists, physician assistants, nurse practitioners, nurses, nursing assistants, physical therapist assistants, psychologists, clinical social workers, licensed or certified alcohol and drug counselors (LADAC, ICRC-AODAC, NAADAC I, II, or Master level NAADAC certification), Licensed social workers (LCSW), licensed professional counselors (LPC), licensed psychological examiners (LPE), or licensed marriage and family therapists (MFT).

D. Qualified Health Care Professional: Includes physicians, mid-level providers, nurses, dentists, mental health professionals, physical therapist, and others, who by virtue of their education, credentials, and experience are permitted by Tennessee law to evaluate and care for inmates.

V. POLICY: Inmates within the physical custody of the TDOC shall have timely access to the appropriate level of health care on a 24-hour a day basis. Health services shall be provided with respect to the inmate's autonomy and privacy, and without discrimination.

VI. PROCEDURES:

A. General:

1. The Health Administrator shall generate institutional written procedures to ensure that routine and emergency health care services are accessible to all inmates in a timely manner. The procedure shall detail the inmate's access to sick call, dental

care, psychological/psychiatric care, and emergency care as outlined in Section VI. (D)(2) of this policy.

2. The Warden/Superintendent shall appoint an individual to educate staff to assist disabled inmates with questions, problems, or issues associated with their disabilities. This individual shall be trained in the Department's responsibilities concerning the Americans with Disabilities Act (ADA).

B. Health Orientation:

1. Upon admission to any institution, each inmate shall receive instructions for accessing health care services. This shall be done during the inmate's initial screening (See Policy #113.20). If the inmate cannot speak English, the Warden/Superintendent or designee shall provide an interpreter to provide verbal health orientation within five working days.

2. Written instructions concerning access to health care shall also be given to each inmate upon entry into the institution. The instruction may be in the form of an information sheet or may be included in an orientation manual, such as the inmate handbook. These instructions shall include at minimum:

a. The location of the clinic at the institution

b. Access to and times of sick call

c. Access to emergency care

d. Procedures for acquiring dental and mental health services

3. The institution shall provide a staff member to read the written instructions to inmates who are unable to read.

4. Health orientation shall be documented on the Health Screening, CR-2178. (See Policy #113.22) The inmate shall sign the form indicating that he/she has received instruction on how to obtain health care.

5. Written instructions explaining access to health care services shall be posted in all living areas and shall be in terms that can be understood by all inmates. Interpretation shall be made available for inmates with intellectual deficiencies and/or language barriers.

C. Routine Health Care: Sick call/triage of health complaints shall be in accordance with Policy #113.31.

D. Emergency Care: Institutional policies and/or procedures shall be developed to include the following requirements:

1. Emergency Response Education/Training:

a. Cardiopulmonary Resuscitation (CPR): All correctional officers and qualified clinical personnel shall maintain current certification in CPR.

b. First Aid: Correctional officers and other institutional employees designated by the Warden/Superintendent shall be certified in first aid. [See Section VI. (E)].

c. Four Minute Response: All institutional staff shall receive training in four-minute response to health-related emergencies. Training shall be part of the new hire orientation and the institutional core curriculum for current employees. It shall include:

(1) Recognition of signs and symptoms of acute medical or mental distress and knowledge of action required in potential emergency situations

(2) Methods of obtaining assistance

(3) Signs and symptoms of mental illness, retardation, and chemical dependency

(4) Procedures for patient transfers to appropriate medical facilities or health care providers

(5) Prevention of blood borne, and air borne infection during CPR/first aid assistance.

Documentation of training and certifications shall be maintained by the institutional training officer. Institutional facilities shall offer CPR, first-aid, and four-minute response training as part of the institutional core curriculum training.

2. Procedures: The institution shall have a written plan which covers the provision of 24-hour emergency medical, dental, and mental health care availability for inmates. The plan shall include arrangements for the following:

a. On-site emergency first aid and crisis intervention

b. Emergency evacuation of the inmates from the facility

c. How to contact local emergency responders

d. Use of one or more designated hospital emergency rooms or other appropriate health facilities

e. Emergency on-call physician, dentist, and mental health professional services when the emergency health facility is not located in a nearby community

f. Security procedures that provide for the immediate transfer of inmates when appropriate

g. Emergency on-call procedures for personnel

h. Location of emergency equipment and supplies within the institution, including stretchers and first aid kits/equipment

i. Scheduled inspection, inventory, replenishment, and maintenance of emergency equipment and supplies

j. Orientation/training of institutional staff on emergency procedures to include four-minute response training

3. First aid and emergency stabilization for employees, volunteers, and visitors shall be provided in accordance with Policy #113.13

4. When emergency on-call physicians, dentists, and mental health professionals are contacted, the nurse shall document the time the call was placed and the time of response on the Progress Note, CR-1884.

E. First Aid:

1. In the event of sudden illness or injury, first aid shall be rendered by any employee to the extent possible within his/her training and experience.

2. Employees certified in CPR are expected to provide assistance in the event of a life-threatening emergency. First aid shall be continued until the arrival of health care personnel. Health care personnel shall take charge and assume responsibility for the emergency upon arrival. They shall direct other employees whom are properly trained to assist in the emergency as required.

F. Health Care for Inmates in Segregation/Detention:

1. When an offender is transferred to segregation/restrictive housing, the unit supervisor will inform health care staff immediately. Health care staff will provide a screening and review, as indicated by the protocols established by the health administrator. The screening and review will be documented in the health record on the Restrictive Housing Health Screening, CR-4270, and filed in Section IX. Unless medical attention is needed more frequently, all inmates shall be seen in the segregation/restrictive housing unit by a qualified health care professional within 24 hours after segregation/restrictive housing placement. A qualified health care professional shall visit each offender in segregation/restrictive housing daily.

2. Inmates housed in segregation, detention, or holding units shall not forfeit their right of access to health care and shall receive daily visits seven days per week from health care staff. This visit shall be documented on the Restrictive Housing Medical Notes, CR-4167, and filed in Section nine of the health record. Evaluation of routine health-related complaints shall be conducted on a daily basis; each inmate requesting to be seen shall be evaluated by a qualified health care

professional. Health care staff must sign each inmate's Segregation Unit Record Sheet, CR-2857-1 or CR-2857-2, or a Segregation Unit Record Sheet for Death Sentenced Inmates, CR-3063, to indicate access to health care has been offered on a daily basis. The initial assessment and all subsequent encounters where services are provided shall be documented in the inmate's health record. The health care staff shall evaluate all emergent or urgent complaints for treatment and disposition as appropriate.

3. The health care staff shall evaluate all emergent or urgent complaints for treatment and disposition as appropriate.

4. When possible, examinations and treatment shall be performed in an appropriately equipped room in the unit. The inmate may be escorted to the clinic or infirmary with appropriate security if required.

5. Inmates housed in segregation, detention, or holding units shall receive their daily prescribed medications.

G. Employee/Volunteer/Visitor First Aid and Emergency Care: First aid and/or lifesaving/stabilizing emergency care shall be provided to employees, volunteers, and visitors experiencing acute illness or injury within the institutional property/grounds in accordance with Policy #113.13. When care is rendered to an individual, it is essential that the individual be referred to his/her own physician or an emergency room for follow-up care. The health care provider shall document the accident or incident on Accident/Incident/Traumatic Injury Report, CR-2592. (See Policy #113.53) NOTE: In the event a state employee is injured on the job and is seeking medical care, the state employee must choose a provider (doctor or hospital) from the current contract approved vendor list as per Policy #303.04.

VII. ACA STANDARDS: 5-ACI-4A-12, 5-ACI4A-15, 5-ACI-6A-01, 5-ACI-6A-08, 5-ACI-6B-08, 5-ACI-4A-01, 5-ACI-4B-28, and 5-ACI-5E-03.

VIII. EXPIRATION DATE: February 1, 2025

TENNESSEE DEPARTMENT OF CORRECTION

PROBLEM ORIENTED – PROGRESS RECORD

INSTITUTION

INMATE NAME: _____ TDOC ID: _____

DATE	TIME	

Do Not Write on Back

TENNESSEE DEPARTMENT OF CORRECTION
HEALTH QUESTIONNAIRE

INMATE NAME: _____ TDOC ID _____ DOB _____

RECEIVING INSTITUTION: _____ DATE: ____/____/_____ TIME: _____ a.m./p.m.

INITIAL INTAKE: _____ TEMPORARY TRANSFER: _____ PERMANENT TRANSFER: _____

INQUIRE:

1. Do you have any barriers to learning? ☐ Vision ☐ Hearing ☐ Reading ☐ Writing ☐ None
2. Do you speak/read English? Speak: ☐ Yes ☐ No Read: ☐ Yes ☐ No
3.. Have you ever had a positive TB test? ☐ Yes ☐ No If **yes**, describe _____
4. Are you being treated for any illness or health problem (*including dental, venereal disease, or other infectious diseases*)?
   ☐ Yes ☐ No If **yes**, describe: _____
5. Do you have any physical, mental or dental complaints at this time? ☐ Yes ☐ No
   If **yes**, describe: _____
6. Are you currently taking any medication(s)? ☐ Yes ☐ No
   If **yes**, was the medication transferred with the inmate? ☐ Yes ☐ No
   If **yes**, describe (what used, how much, how often, date of last use, and any problems)
7. Have you recently or in the past, abused alcohol or other drugs, including prescription drugs? ☐ Yes ☐ No
   If yes, What? _____ How much? _____
8. Have you ever been hospitalized for using alcohol or other drugs, including prescription drugs? ☐ Yes ☐ No
   If **yes**, when? _____
9. Do you have any allergies? ☐ Yes ☐ No If **yes**, describe: _____

(For women)

10. a) LMP _____ b) Are you pregnant? ☐ Yes ☐ No Number of months _____
    c) Have you recently delivered? ☐ Yes ☐ No Date: _____
    d) Are you on birth control pills? ☐ Yes ☐ No
    e) Any gynecological problems? ☐ Yes ☐ No
11. Screening for MRSA Infections:
    a) Do you have any lesions, sores or insect bites? ☐ Yes ☐ No
    If **so**, do you have any open/draining lesions, sores, or insect bites? ☐ Yes ☐ No
    If **yes**, where are these lesions? _____

OBSERVE:

1. Behavior (including state of awareness, mental status, appearance, conduct, tremor and sweating):
   ☐ Normal ☐ Abnormal If **abnormal**, describe: _____
2. Skin Assessment (*including needle marks, trauma markings, bruises, lesions, jaundice, rashes, tattoos, and infestation(s)*
   ☐Yes ☐ No
   If **yes**, describe: _____
3. Is there evidence of Abuse or Trauma? ☐ Yes ☐ No If yes, describe: _____

TENNESSEE DEPARTMENT OF CORRECTION
HEALTH QUESTIONNAIRE

MENTAL HEALTH:

1. Is the inmate presenting behavior(s) that are considered: ☐ Anxious ☐ Antagonistic/Hostile ☐ Hallucinations ☐ Withdrawn/Avoidant ☐ Depressed/Hopeless ☐ No
2. Is the inmate presenting disorganized thought? (*Unable to track questions and/or present responses in logical or connected manner*) ☐ Yes ☐ No
3. Have you ever been in a mental hospital? ☐ Yes ☐ No
   If **yes**, when? _____ How often? _____
4. Have you ever been treated for mental health? ☐ Yes ☐ No
   Have you ever been treated for substance use? ☐ Yes ☐ No
5. Have you ever attempted to kill yourself? ☐ Yes ☐ No If **yes**, when? _____
   How? _____ How many times? _____
6. Are you thinking about suicide now? ☐ Yes ☐ No
   If yes, do you have a plan? ☐ Yes ☐ No
7. Has a parent, other family member, or close friend committed suicide? ☐ Yes ☐ No If **yes**, who? _____
8.. Do you have a history of past or current head trauma? ☐ Yes ☐ No If **yes**, explain type of injury: _____
   _____
9.. As an adult or child, have you personally experienced being: ☐ Sexually abused ☐ Physically abused ☐ Emotionally abused
   ☐Yes ☐ No ☐Yes ☐ No ☐Yes ☐ No
   When? (year) and by whom? _____

DISPOSITION:

_____ Intake housing _____ Intake housing with prompt referral appointment *(health, mental health, substance use treatment)*

_____ General housing _____ General housing with prompt/referral appointment

Referred to appropriate health, mental health or substance use provider ☐ Yes ☐ No

Contacted appropriate health, mental health, or substance use provider due to emergency ☐ Yes ☐ No

Additional comments on Progress Notes (CR-1884): ☐ Yes ☐ No

I have received information regarding the procedure for obtaining routine and emergency health care (*medical, dental, substance use, and/or mental health, prenatal and postpartum care for females, and co-pay requirements*). These have been explained to me and I understand how to access healthcare services in the form of:

☐ **Orientation Handbook (i.e. Inmate Handbook)**
☐ **Transient inmate information-describing how to access healthcare**
☐ **Females only: I have received the handout entitled "Disclosures Required by TCA 41-21-204**

_____
Inmate Signature

_____
Employee Name Printed

_____
Employee Signature and Title

TENNESSEE DEPARTMENT OF CORRECTION

ACCIDENT / INCIDENT / TRAUMATIC INJURY REPORT

_____
INSTITUTION/DISTRICT/LOCATION

EMPLOYEE NUMBER: _____ TDOC ID: _____

Name: _____ Number: _____ Date of Birth: _____
Last First Middle

☐ Employee ☐ Inmate ☐ Visitor ☐ Other _____

Location (of occurrence) _____ Date (of occurrence) _____ Time (of occurrence) _____

Type of Injury / Incident: ☐ Work-related ☐ Sports ☐ Violence
☐ Use of Force ☐ Other: _____

Weapon, Property, Equipment, Machinery Involvement (Specify): _____

Subject's Version (how situation occurred): _____

_____

_____ _____
Signature of Subject

Witness' Version: _____

_____

_____ _____
Printed Name of Witness Signature of Witness

Health Service Provider's Report

Subjective: _____

_____

Objective: _____

_____

Assessment: _____

_____

Plan: _____

_____

_____ _____ _____
Date of Treatment Time Signature of Health Service Provider

Disposition:
☐ Treated by Institutional Health Service Staff
☐ Transported to Community Facility for Outpatient Care: _____ Facility
☐ Transported to Community Hospital for Inpatient Care: _____ Hospital
☐ Other, explain: _____

Did death result? ☐ Yes ☐ No Relatives notified: ☐ Yes ☐ No

Workers Compensation Claim #: _____

TENNESSEE DEPARTMENT OF CORRECTION

SEGREGATION UNIT RECORD

_____

INSTITUTION

INMATE NAME: _____ TDOC ID: _____ CELL: _____

TYPE OF SEGREGATION (Circle One):

ADMINISTRATIVE ☐ MANDATORY ☐ PUNITIVE ☐ PH ☐ PI ☐ PC ☐ PCI ☐

DATE RECEIVED: _____ DATE RELEASED: _____

IF PUNITIVE: CHARGE _____ PUNITIVE TIME _____

PERTINENT INFORMATION (*Examples: Epileptic, Diabetic, Suicidal, Assaultive, etc*.) _____

DATE	SHIFT	SHIFT OFFICER SIGNATURE	B	D	S	SHO	SHA	TIME EXERCISE		MEDICAL STAFF SIGNATURE	SUPERVISOR SIGNATURE	PROGRAM
								OUT	IN			
SUN	1st											
	2nd											
	3rd											
MON	1st											
	2nd											
	3rd											
TUE	1st											
	2nd											
	3rd											
WED	1st											
	2nd											
	3rd											
THUR	1st											
	2nd											
	3rd											
FRI	1st											
	2nd											
	3rd											
SAT	1st											
	2nd											
	3rd											

Meals/Shower/Shave: Yes (Y) Not Offered (N) Refused (R)

Exercise: Enter actual time period (i.e., 9:30 OUT/10:00 IN) : Yes (Y) Not Offered (N) Refused (R)

Medical Staff: On a daily basis, inmates shall have access to medical/nursing staff.

This shall be documented by signing the unit log and segregation unit record each time the inmate is seen.

DATE	SHIFT	SHIFT OFFICER SIGNATURE	B	D	S	SHO	SHA	TIME EXERCISE		MEDICAL STAFF SIGNATURE	SUPERVISOR SIGNATURE	PROGRAM
								OUT	IN			
SUN	1st											
	2nd											
	3rd											
MON	1st											
	2nd											
	3rd											
TUE	1st											
	2nd											
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WED	1st											
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THUR	1st											
	2nd											
	3rd											
FRI	1st											
	2nd											
	3rd											
SAT	1st											
	2nd											
	3rd											

Meals/Shower/Shave: Yes (Y) Not Offered (N) Refused (R)
Exercise: Enter actual time period (i.e., 9:30 OUT/10:00 IN) : Yes (Y) Not Offered (N) Refused (R)
Medical Staff: On a daily basis, inmates shall have access to medical/nursing staff.
This shall be documented by signing the unit log and segregation unit record each time the inmate is seen.

REMARKS/COMMENTS:

TENNESSEE DEPARTMENT OF CORRECTION

SEGREGATION UNIT RECORD

_____

INSTITUTION

INMATE NAME: _____ TDOC ID: _____ CELL: _____

TYPE OF SEGREGATION (Circle One):

ADMINISTRATIVE ☐ MANDATORY ☐ PUNITIVE ☐ PH ☐ PI ☐ PC ☐ PCI ☐

DATE RECEIVED: _____ DATE RELEASED: _____

IF PUNITIVE: CHARGE _____ PUNITIVE TIME _____

PERTINENT INFORMATION (*Examples: Epileptic, Diabetic, Suicidal, Assaultive, etc*.) _____

_____

DATE	SHIFT	SHIFT OFFICER SIGNATURE	B	D	S	SHO	SHA	TIME EXERCISE		MEDICAL STAFF SIGNATURE	SUPERVISOR SIGNATURE	PROGRAM
								OUT	IN			
SUN	1st											
	2nd											
MON	1st											
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TUE	1st											
	2nd											
WED	1st											
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THUR	1st											
	2nd											
FRI	1st											
	2nd											
SAT	1st											
	2nd											

Meals/Shower/Shave: Yes (Y) Not Offered (N) Refused (R)
Exercise: Enter actual time period (i.e., 9:30 OUT/10:00 IN) : Yes (Y) Not Offered (N) Refused (R)
Medical Staff: On a daily basis, inmates shall have access to medical/nursing staff.
This shall be documented by signing the unit log and segregation unit record each time the inmate is seen.

DATE	SHIFT	SHIFT OFFICER SIGNATURE	B	D	S	SHO	SHA	TIME EXERCISE		MEDICAL STAFF SIGNATURE	SUPERVISOR SIGNATURE	PROGRAM
								OUT	IN			
SUN	1st											
	2nd											
MON	1st											
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WED	1st											
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THUR	1st											
	2nd											
FRI	1st											
	2nd											
SAT	1st											
	2nd											

Meals/Shower/Shave: Yes (Y) Not Offered (N) Refused (R)
Exercise: Enter actual time period (i.e., 9:30 OUT/10:00 IN) : Yes (Y) Not Offered (N) Refused (R)
Medical Staff: On a daily basis, inmates shall have access to medical/nursing staff.
This shall be documented by signing the unit log and segregation unit record each time the inmate is seen.

REMARKS/COMMENTS:

TENNESSEE DEPARTMENT OF CORRECTION
RIVERBEND MAXIMUM SECURITY INSTITUTION
SEGREGATION UNIT RECORD FOR DEATH SENTENCED INMATES

INMATE NAME: _____ TDOC ID: _____ LEVEL: _____

CELL LOCATION: _____ MONTH _____ DAY _____ YEAR _____

PERTINENT INFORMATION _____

DATE	MEALS			SHOWERS	WORK	TRICOR WORKERS ONLY	SCHOOL	PHONE	RECREATION	FREE TIME	ARTS AND CRAFTS	VISITATION	LEGAL VISITS	LAW LIBRARY	RELIGION
	Breakfast	Lunch	Dinner												
1															
2															
3															
4															
5															
6															
7															
8															
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27															
28															
29															
30															
31															

- ***SEE REVERSE SIDE FOR COMMENTS / PERTINENT INFORMATION LEGEND ****

Y = Yes
N = No
R = Refused
G = 1 ½ hour "Out of Cell Time" for Group Meals

AP = Attorney Phone Call
P = 30 Minute in Pod Phone Call
A = Alternate Entreé
MD = Modified Diet

Attorney Visit	Haircuts	Others	Medical	COMMENTS:	Signature's			DATE
					1st	2nd	3rd	
								1
								2
								3
								4
								5
								6
								7
								8
								9
								10
								11
								12
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								30
								31

TENNESSEE DEPARTMENT OF CORRECTION

RESTRICTIVE HOUSING MEDICAL NOTES

_____
Institution

Inmate/Patient: _____ **TDOC ID:** _____ **:** **UNIT:** _____

Date entered Restrictive Housing: _____ **Date released Restrictive Housing:** _____

Comments/Behavior Observed

1. AA&Ox3
2. Request Sick Call
3. Up at door
4. Lying on bed
5. Walking around cell
6. Restless/Pacing
7. Swearing/Name Calling
8. Hostile/Threatening
9. Crying
10. Quiet/Not Talking
11. Inappropriate Behavior
12. Incoherent
13. Talking
14. Anxious
15. Denies any complaints
16. Other, explain in comments

(Use as many codes as needed)

Date	Time	Codes				Comment	Signature

TENNESSEE DEPARTMENT OF CORRECTION
RESTRICTIVE HOUSING HEALTH SCREENING

INMATE NAME: _____ TDOC ID _____ DOB _____

RECEIVING UNIT: _____ DATE: ____/__/____ TIME: _____ a.m./p.m.

INQUIRE:

1. Do you have any barriers to learning? ☐ Vision ☐ Hearing ☐ Reading ☐ Writing ☐ None
2. Do you speak/read English? Speak: ☐ Yes ☐ No Read: ☐ Yes ☐ No
3. Are you thinking about suicide now? ☐ Yes ☐ No If yes, do you have a plan? ☐ Yes ☐ No
4. Have you ever attempted to kill yourself? ☐ Yes ☐ No If **yes**, when? _____

   How? _____ How many times? _____
5. Are you currently prescribed any psychotropic medication(s)? ☐ Yes ☐ No If **yes,** what used, how much, how often, date of last dose, any problems)_____
6. Do you have any physical, mental, or dental complaints at this time? ☐ Yes ☐ No If **yes**, describe: _____

   _____
7. Are you currently being treated for mental health? ☐ Yes ☐ No
8. Have you ever been in a mental hospital? ☐ Yes ☐ No

   If **yes**, when? _____How often?_____
9. Have you ever been treated for substance use? ☐ Yes ☐ No

OBSERVE:

1. Behavior (including state of awareness, mental status, appearance, conduct, tremor and sweating):

   ☐ Normal ☐ Abnormal If **abnormal**, describe: _____

   _____
2. Skin Assessment (*including needle marks, trauma markings, bruises, lesions, jaundice, rashes, tattoos, and infestation(s)*

   ☐ Yes ☐ No

   If **yes**, describe: _____
3. Is there evidence of Abuse or Trauma? ☐ Yes ☐ No If yes, describe: _____
4. Is the inmate presenting behavior(s) that are considered: ☐ Anxious ☐ Antagonistic/Hostile ☐ Hallucinations ☐ Withdrawn/Avoidant ☐ Depressed/Hopeless ☐ No
5. Is the inmate presenting disorganized thought? (*Unable to track questions and/or present responses in logical or connected manner*) ☐ Yes ☐ No

DISPOSITION:

Referred to appropriate health, mental health, or substance use provider ☐ Yes ☐ No

Contacted appropriate health, mental health, or substance use provider due to emergency ☐ Yes ☐ No

_____
Inmate Signature

_____
Employee Name Printed

_____
Employee Signature and Title