

 <p style="text-align: center;">ADMINISTRATIVE POLICIES AND PROCEDURES State of Tennessee Department of Correction</p>	Index #: 113.04	Page 1 of 10
	Effective Date: June 1, 2018	
	Distribution: A	
	Supersedes: 113.04 (3/1/12)	
Approved by: Tony Parker		
Subject: MEDICAL REQUIREMENTS FOR THE RELEASE/TRANSFER OF INMATES		

- I. AUTHORITY: TCA 4-3-603 and TCA 4-3-606.
- II. PURPOSE: To establish standardized procedures to be used in the release or medical transfer of inmates.
- III. APPLICATION: Assistant Commissioner of Prisons, Wardens/Superintendents, Associate Wardens of Treatment (AWT)/Deputy Superintendents, Health Administrators, health care staff, privately managed institutions, medical contractors, security staff, and inmates.
- IV. DEFINITIONS:
  - A. Central Dispatch Office (CDO): A function of the office of the Director of Classification Programs that coordinates and schedules inter-institutional transfers and inmate transportation.
  - B. Central Transportation: A division of the DeBerry Special Needs Facility (DSNF) that coordinates, schedules, and performs local inmate transportation in the Metro Nashville/Davidson County area.
  - C. DeBerry Special Needs Facility (DSNF) Scheduler: The DSNF employee(s) assigned to coordinate the scheduling of approved inmate specialty consultation services and associated transportation services.
  - D. DSNF Health Care Center: The skilled units (I, II, and III) at DSNF, used for inmates requiring long-term nursing care.
  - E. DSNF Sheltered Living Unit: A housing unit at DSNF utilized for inmates with limited ability to ambulate who require close proximity to health services, who need a low risk environment due to progressive illness, or who have a physical health condition that does not allow them to be housed in other Tennessee Department of Correction (TDOC) locations
  - F. Emergency Medical Transfer: An unexpected inmate housing assignment occurring as the result of a life-threatening medical situation requiring immediate medical attention not available at an inmate's institution.
  - G. Online Sentinel Event Log (OSEL): TDOC's electronic health services designated website for the reporting of clinical decisions necessitating mediation from Central Office or an event significant enough to impact daily operations of health and behavioral health care services within the facility. Examples may include, but not limited to emergency room visits, facility infirmary admissions, direct hospital admissions, suicide watch, mental health seclusion, suicide attempts, deaths, lockdowns, equipment failure and so forth.

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- H. Permanent Medical Transfer: Reassignment to another TDOC facility occurring when an inmate requires specialized treatment, prolonged rehabilitative services, or closer proximity to medical care that cannot be provided at the sending facility.
- I. Regional Sub-Acute Centers (RSAC): Designated regional institutions that care for inmates with an illness or medical condition as diagnosed by an appropriate health care provider that requires care above medical/nursing observation but does not require admission to an acute care hospital.
- J. Temporary Medical Transfer: A temporary housing reassignment occurring for the purpose of completing a scheduled specialty medical appointment or for medical evaluation.
- K. Transfer/Discharge Summary: A brief summary of the patient's course and present health status, made prior to a patient's transfer to another provider or upon the patient's discharge from care, and which identifies the treatment and services the individual will need upon transition to another care setting or to the community.
- L. Utilization Management Entity (UME): The person(s) or contractor designated by the TDOC to process all requests for inpatient and outpatient specialty care.
- V. POLICY: Inmates who present clinical care needs that are beyond those available at his/her assigned institution, will be transferred to another institution the appropriate services are available.
- VI. PROCEDURES:
- A. Whenever possible, resources available within TDOC facilities shall be utilized for health, services referrals.
- B. The institutional physician, dentist, or designee shall be responsible for the identification of acute/chronic medical or dental conditions that are beyond the diagnostic and/or treatment resources available at their facility. (See Policy #113.82.1 for procedures for mental health release/transfer).
- C. Routine Coordination:
1. The health administrator or designee shall communicate the need for an inmate transfer to the Warden/Superintendent or (AWT)/Deputy Superintendent and shall assist in the coordination of the transfer with the receiving facility. Transfers shall be accomplished in accordance with Policy #403.01.
  2. Long distance transfers for health, reasons should not be considered if, in the opinion of the physician or mental health professional, such delay or travel could adversely affect the health of the inmate. In such cases arrangements for necessary care shall be made at an appropriate health care facility near the institution. When the long distance transfer of acutely ill inmates is indicated, the sending institution's attending physician shall authorize the transfer and determine the appropriate method of transportation.

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If the inmate is in a local community hospital, the receiving institutional physician shall obtain the concurrence of the community hospital physician attending the inmate prior to transfer. The receiving institutional physician shall communicate the transfer activity with the receiving institution's charge nurse.

- D. Emergency Medical Transfers: In an emergency situation where routine coordination is not possible, the on-duty referring health professional shall complete and send the Referral for Emergency Care, CR-3425, with the inmate to ensure continuity of care between the sending and receiving institutions. In cases where ambulance services are not utilized, the senior on-site health care professional shall decide if a medical escort is necessary. Appropriate facilities for transfer include the following:
1. Local Licensed Hospital: All inmates in need of immediate medical room or emergency center.
  2. Secure Hospital: As medically, appropriate, inmates requiring hospitalization are to be transferred to the designated licensed hospital with a secure unit.
  3. TDOC Skilled Nursing Unit(s): Male inmates requiring skilled nursing care are to be housed at DSNF Health Care Center. Female inmates requiring skilled nursing care are to be housed at the Tennessee Prison for Women (TPFW).
- E. Notification of Emergency Transfer: The health administrator or their designee shall be responsible for electronically notifying the TDOC Chief Medical Officer (CMO), of emergencies within six hours after transfer via the Online Sentinel Event Log, in accordance with Policy #113.54.
- F. Clinical Transfer of an Inmate Sentenced to Death (ISD):
1. Emergent transfers of an ISD away from the facility require immediate notification to the office of the TDOC Chief Medical Officer and the Assistant Commissioner of Prisons.
  2. All temporary medical transfers for ISDs must be authorized by the TDOC CMO/designee prior to transfer.
  3. All scheduled services provided for ISDs shall be completed at DSNF, unless service can only be provided elsewhere.
  4. Transfers of ISDs to a facility outside of TDOC: The Assistant Commissioner of Prisons and the Warden or Warden's designee shall be notified. The Assistant Commissioner of Prisons may request assistance from the Director of the Office of Investigations and Compliance (OIC) for security team assignment.
- G. Temporary Medical Transfers:
1. In accordance with Policy #113.12, inmates may be temporarily transferred for specialty care consultations and diagnostic testing. These services may be primarily provided at one of the RSACs.

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2. Whenever such a transfer is approved, the health administrator or designee at the sending institution shall coordinate the transfer with the health administrator at the receiving institution in advance.
3. The routine transfer of inmates for medical reasons shall be accomplished in the following process and in accordance with Policy #403.01.
  - a. The DSNF scheduler shall record approved consultations and appointments on the LIMA screen in the offender management screen (OMS).
  - b. Institutional health care staff shall be responsible for inmate evaluation and medical clearance for travel. Upon a physician or mid-level provider's review of an inmate's medical record, the health administrator/designee shall determine if the inmate's medical or health conditions require special transportation, or medical escort, and record this information on LIMA. The health administrator/designee shall determine if an inmate's condition prohibits transportation on a Central Transportation vehicle, requires transport by ambulance or specially equipped vehicle, and/or requires escort by a member of the medical staff. Special conditions and precautions shall be promptly communicated with transportation personnel and the receiving/sending institution.
  - c. The health administrator/designee shall ensure that the inmate is transported with all necessary resources including the health record, medications, and any other information or equipment required for the inmate's safety and management. These shall be documented on Health Records Movement Document, CR-2176, and in the inmate's health record. Information and instructions for special treatment and/or medications shall be written in a manner readily accessible and easily understood by escorting and receiving personnel.
  - d. When an inmate refuses to be transported for a scheduled appointment, when a consultation or appointment is no longer required, or when a consultation or appointment is cancelled for any reason, it shall be documented and explained on LIMA by health staff at the institution at which the refusal or cancellation occurred. The health services staff shall immediately notify the DSNF Scheduler, the utilization management entity, and (if applicable) Central Dispatch Office. The DSNF scheduler shall notify Central Transportation of the cancellation.
  - e. In the rare event that the Warden is unable to comply with the physician's recommendation for medical transfer due to overriding concerns such as security, he/she shall provide a written explanation to the CMO and the Commissioner. The Warden shall consult the TDOC CMO for assistance in determining alternative treatment measures.

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- H. Return from Medical Transfer: The TDOC UME will notify the appropriate vendor's statewide supervising physician (SSP), or designee, when an inmate has been released for discharge from a hospital or emergency care center. The SSP, or designee, will coordinate with the CMO, or designee, to determine appropriate bed placement related to inmate acuity. The SSP, or designee, will notify the receiving facility's medical director for admission in the appropriate bed placement within the respective facility, i.e. infirmary, observation, or cell bed.
- I. Permanent Medical Transfers:
1. A permanent transfer to another TDOC facility should be considered when an inmate requires an extended period of specialized treatment, prolonged rehabilitative services, close proximity to specialty medical care, or environmental needs which cannot be provided at the sending facility.
  2. The Warden or designee shall be informed by the health administrator of the need for such a transfer in writing or by e-mail. Written notification shall include the relative seriousness of the case, the period of time within which the transfer should be affected, the type of transportation necessary, and whether the inmate requires a medical escort, any medications or care necessary while the inmate is enroute. If it is likely that an inmate may require medical attention en route, transportation alternatives to the chain bus (such as ambulance transport) shall be considered.
  3. The TDOC CMO has the final decision regarding medically related placements in TDOC institutions and may overrule medical placement decisions of other physicians. If any physician feels that he/she should appeal a medical placement decision, he/she shall send a written memorandum or e-mail to the TDOC CMO and include the rationale for his/her appeal. Transfers to TDOC medical units shall be conducted as follows:
    - a. DSNF Long Term Nursing Care Unit: Any physician at the TDOC institution who believes that a male inmate is appropriate for placement in the Long Term Nursing Care Unit, shall make a written request to the DSNF Medical Director that includes why the treatment or management plan cannot be accomplished at the current facility and why the transfer to DSNF Long Term Nursing Care Unit is necessary.
      1. The physician shall prepare a memorandum justifying (in detail) the inmate's physical needs that qualify him to be placed in the Long Term Nursing Care Unit. The memorandum shall outline the inmate's:
        - (a) Medical history
        - (b) Diagnoses
        - (c) Medications

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2. The office of Health Services may obtain a copy when requested.
  - b. DSNF Health Care Center: The DSNF Medical Director shall review the written request within seven days of receipt. He/she shall then contact the requesting physician and provide a response to the request for transfer. The DSNF Medical Director has authority over admissions and discharges to the health care center. However, in the event there is a disagreement between any physicians regarding placement for medical reasons, the TDOC CMO or designee shall have the final authority over placement.
  - c. If there is an appeal by any physician regarding a medical placement at DSNF or any other institution, the TDOC CMO or designee shall respond by letter or e-mail to all involved physicians, and inform classification of his/her placement decision.
  - d. Once a medical placement decision is finalized, transfers shall be made in accordance with Policy #403.01
- J. Pre-Release Requirements: Upon notification that an inmate is scheduled to be paroled or expire his/her sentence, the health services administrator or designee shall forward a current copy of the Transfer/Discharge Health Summary, CR-1895, to the counselor. In addition, the health care staff shall ensure that any necessary referrals are made to local health care providers and community resources. In accordance with Policy #113.70, the health services staff shall ensure that the inmate receives at least a 30-day supply of all current medications.
- K. Health Records:
  1. In accordance with Policy #403.01.1 and to ensure continuity of care and prevent the duplication of examinations, diagnostic tests, and treatment at the receiving facility, the health record shall accompany the inmate whenever he/she is transferred either temporarily or permanently to another TDOC facility. This activity shall be coordinated by the institution's records office and the institution's health service staff at least 24 hours before a routine transfer.
  2. Whenever the health record is to leave the facility copies of the following records are to be maintained at the sending facility until receipt of the health record is verified by the receiving institution:
    - a. Current Medication Administration Record
    - b. Problem List
    - c. Last CCC/Treatment Plan note
    - d. Past 48 hours Problem Oriented Progress Records

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3. The Transfer/Discharge Health Summary, CR-1895, shall be completed and signed with the full legal signature of the health care professional completing the form. The completed form shall be attached to the inmate health record (which is sealed in a manila envelope).
4. The Health Records Movement Document, CR-2176, "Comments" section, shall be completed by the health care professional to alert the transportation official of any special precaution or care necessary for the inmate while en route. Specific types of information shall include the following:
  - a. Medication needs during transit
  - b. Special medical conditions such as diabetes and seizure disorders
  - c. Suicidal tendencies or potentially dangerous behavior caused by mental status (See #5 below)
  - d. Physical disabilities that may require special care during transportation, or upon entering the receiving institution
  - e. Isolation precautions, specifying type
5. When suicidal tendencies or potentially dangerous behavior caused by mental health status is present the Psychiatric Intake Update, CR-3487, shall be completed by a mental health provider. The completed form shall be attached to the inmate health record with the Transfer/Discharge Health Summary, CR-1895.
6. If an inmate is transferred to a jail, or to any other law enforcement agency for custodial care, a Transfer/Discharge Health Summary, CR-1895, shall be completed by the health care provider, signed with full legal signature and professional title, and forwarded with the inmate. Also, a 30 day supply of the inmate's medications shall be sent with the inmate to the destination. The medications should be clearly labeled with the inmate's name, and the medication name, and dosage instructions. The clinic shall be notified 24 hours prior to transfer whenever possible. The original health record shall be archived as outlined in Policy #113.50.
7. Transfer without Health Records:
  - a. If an inmate arrives at the receiving institution without health care records, the receiving facility's health administrator shall immediately notify the transferring facility's health administrator and arrange for the sending institution to transfer the records as soon as possible and report on the Online Sentinel Event Log (OSEL) Any pertinent information needed by the receiving facility shall be faxed immediately. If the requested information is not received within 24 hours, the receiving health administrator shall notify the Warden so that further action can be taken to secure the health record.

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b. Until the complete health care record arrives, current medical information, including allergies, is to be noted on a progress note. This information may be obtained from the sending institution's health care staff or through an interview with the inmate. The receiving facility shall contact the pharmacy and request a copy of the current medication orders.

8. Protected health information shall not be disclosed to an unauthorized third party other than as stated in Policies #103.04, #113.52, and #512.01.

VII. ACA STANDARDS: 4-4347, 4-4348, 4-4349, 4-4368, 4-4389, and 4-4414.

VIII. EXPIRATION DATE: June 1, 2021.





TENNESSEE DEPARTMENT OF CORRECTION  
REFERRAL FOR EMERGENCY CARE

\_\_\_\_\_  
INSTITUTION

Name: \_\_\_\_\_  
Last First Middle TDOC Number Date

Date of Birth: \_\_\_\_\_ Race: \_\_\_\_\_ Referring Institution: \_\_\_\_\_

Current Complaint/Pertinent History: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies: \_\_\_\_\_ Current Medication(s): \_\_\_\_\_

Treatment Given Prior To Transfer Including Immunization: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Facility Referring To: \_\_\_\_\_

Referral Coordinated With (Name): \_\_\_\_\_ Phone: \_\_\_\_\_ Time: \_\_\_\_\_

Ambulance Service Utilized: \_\_\_\_\_ Date: \_\_\_\_\_ Time Requested: \_\_\_\_\_

Referring TDOC Health Professional: \_\_\_\_\_ Phone: \_\_\_\_\_  
Signature/Professional Title

-----  
**\* REPORT FROM OUTSIDE FACILITY**

Date Patient Received: \_\_\_\_\_ Time: \_\_\_\_\_ Emergency Facility: \_\_\_\_\_

Treatment Given: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Diagnosis: \_\_\_\_\_

Recommend Disposition/Follow-up: \_\_\_\_\_

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

\* May attach copy of Emergency Room Report in lieu of completing above report.



**TENNESSEE DEPARTMENT OF CORRECTION  
HEALTH RECORDS/MEDICATION MOVEMENT DOCUMENT**

**DESTINATION:** \_\_\_\_\_

**THIS PACKET CONTAINS HEALTH RECORDS ON THE FOLLOWING INMATE(S):**

**CHECK ALL THAT APPLY**

	<u>Inmate Name</u>	<u>Number</u>	<u>Health Record</u>	<u>Dental Record</u>	<u>Medication</u>	<u>* Purpose</u> (Indicate <b>A, B, C</b> or <b>D</b> )
1.	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
2.	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
3.	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
4.	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
5.	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
6.	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
7.	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
8.	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
9.	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
10.	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

**\* PURPOSE OF RECORDS MOVEMENT:**

- A.** Permanent Transfer    **B.** Temporary Transfer for Clinical Services    **C.** Record to Archives    **D.** Other (*See Comments*)

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**\* MEDICAL RECORD CHAIN OF CUSTODY**

Sending Institution: \_\_\_\_\_

DATE	RELEASED BY	RECEIVED BY	DATE: IF CONTINUING	RELEASED BY	RECEIVED BY
	CLINICAL SERVICES SIGNATURE	TRANSPORT OFFICER SIGNATURE		CLINICAL SERVICES SIGNATURE	TRANSPORT OFFICER SIGNATURE
	NAME & TITLE (PRINT)	NAME & TITLE (PRINT)		NAME & TITLE (PRINT)	NAME & TITLE (PRINT)

DATE	RELEASED BY	RECEIVED BY	DATE:	RELEASED BY	RECEIVED BY
	CLINICAL SERVICES SIGNATURE	TRANSPORT OFFICER SIGNATURE		CLINICAL SERVICES SIGNATURE	TRANSPORT OFFICER SIGNATURE
	NAME & TITLE (PRINT)	NAME & TITLE (PRINT)		NAME & TITLE (PRINT)	NAME & TITLE (PRINT)

**\*\* THIS DOCUMENT SHALL NOT CONTAIN PROTECTED HEALTH INFORMATION \*\***



TENNESSEE DEPARTMENT OF CORRECTION  
**TRANSFER/DISCHARGE HEALTH SUMMARY**

Name of Inmate: \_\_\_\_\_ Inmate Number (TDOC/IDN): \_\_\_\_\_

Inmate DOB: \_\_\_\_\_ Sex:  Male  Female

Current Institution/County/Facility: \_\_\_\_\_ Receiving Institution/County/Facility: \_\_\_\_\_

Reason for Transfer/Discharge: \_\_\_\_\_

Requires Chronic Illness Monitoring:  Yes  No Requires Mental Health/Psychiatric Monitoring?  Yes  No

**HEALTH HISTORY** Check (✓) all conditions present

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> HIV/AIDS               | <input type="checkbox"/> Depression             | <input type="checkbox"/> Hernia             | <input type="checkbox"/> Prosthesis (specify) _____       |
| <input type="checkbox"/> Alcoholism             | <input type="checkbox"/> Diabetes               | <input type="checkbox"/> High Cholesterol   | <input type="checkbox"/> Rheumatoid Arthritis             |
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Emphysema              | <input type="checkbox"/> Hypertension       | <input type="checkbox"/> Stroke                           |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Epilepsy               | <input type="checkbox"/> Kidney Disease     | <input type="checkbox"/> Suicide Attempt/Gesture/Ideation |
| <input type="checkbox"/> Cancer (specify) _____ | <input type="checkbox"/> Heart Disease          | <input type="checkbox"/> Liver Disease      | <input type="checkbox"/> Tuberculosis                     |
| <input type="checkbox"/> Chemical Dependency    | <input type="checkbox"/> Hepatitis C            | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Venereal Disease                 |
| <input type="checkbox"/> COPD                   | <input type="checkbox"/> Other (specify): _____ |   |   |

MH Diagnosis(s): \_\_\_\_\_

**MEDICATION ORDERS**

NAME OF DRUG	STRENGTH/ROUTE	FREQUENCY	LAST DOSE DATE/TIME	MEDICATION SENT (Circle Y/N)		AMOUNTS SENT	KOP (Circle Y/N)	
				Yes	No		Yes	No

Brief Summary of Current Problems/Diagnosis(s): \_\_\_\_\_

Special Instructions (e.g. Allergies, Diet, Impairments, Medical Appointments, etc.): \_\_\_\_\_

Referred to Community Resources:  Yes  No Specify: \_\_\_\_\_

**TB INFORMATION**

TB Clearance  Y  N; BCG  Y  No; PPD Completed: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Results: \_\_\_\_\_ CXR Completed \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Health Authority Clearance: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

\_\_\_\_\_  
 Name Title Date

**SPECIAL INSTRUCTIONS/PRECAUTIONS**

Inmate is on Suicide Monitoring or Special Mental Health Observation:  Yes  No Dates: \_\_\_\_\_

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| Is Inmate medically able to travel by BUS, CAR, or VAN?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does the inmate require medication during transport?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does the inmate require medical equipment during transport?                                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does the inmate have communicable disease clearance to travel?                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is the Transport Officer required to use universal precautions and the use of masks or gloves? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Conservator:  Yes (list information below)  No ( If no, list Emergency Contact)

Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Report prepared by: \_\_\_\_\_  
 Health Signature/Professional Title Date

Report prepared by: \_\_\_\_\_  
 Mental Health Signature/Professional Title (if applicable) Date

Receiving Institution: \_\_\_\_\_  
 Signature/Professional Title Date



**TENNESSEE DEPARTMENT OF CORRECTION  
PSYCHIATRIC UPDATE**

\_\_\_\_\_  
INSTITUTION

INMATE NAME: \_\_\_\_\_ TDOC NUMBER: \_\_\_\_\_

                    Last                      First                      Middle

DOB: \_\_\_\_\_ Sex: \_\_\_\_\_ Race \_\_\_\_\_ Custody Status: \_\_\_\_\_ Date: \_\_\_\_\_

**COURSE OF TREATMENT TO DATE**

Define Problem Areas: \_\_\_\_\_

Psychotropic Medications: \_\_\_\_\_

Last Psychiatrist Visit: \_\_\_\_\_

**CURRENT MENTAL STATUS**

History of suicide attempts in the past year:    Yes    No    How many? \_\_\_\_\_

**DIAGNOSTIC IMPRESSIONS**

DSM-V: \_\_\_\_\_

TREATMENT RECOMMENDATIONS: \_\_\_\_\_

\_\_\_\_\_  
Staff Psychiatrist Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff Psychologist Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff Signature/Title

\_\_\_\_\_  
Date