TEXAS UNIFORM HEALTH STATUS UPDATE

I. NAME: _____ DOB: ___/___/___ AGE: _____
Last First MI
STATE ID# _____ RACE: _____ SEX: Male ____ Female _____

COUNTY/TDCJ# _____ WT: _____ HT: _____

II. CURRENT/CHRONIC HEALTH PROBLEMS

A. Health Problems

___ 1. None
___ 2. Asthma
___ 3. Pregnancy
___ 4. Dental Priority
___ 5. Diabetes
___ 6. Drug Abuse
___ 7. Alcoholism
___ 8. Orthopedic Problems
___ 9. Cardiovascular/Heart Trouble
___10. Suicidal
___11. Mental Retardation
___12. Mental Illness (Specify diagnosis) _____
_____
___13. Recent Surgery
___14. Seizures
___15. Dialysis
___16. Hypertension
___17. CARE System Y/N

NOTE: When screening substance abuse facility clients, please contact the Rehabilitation Programs Division Administrator at (512)671-2151 for clients with any chronic disease symptoms deemed unstable.

III. SPECIAL NEEDS (Check all that apply)

A. Housing Restrictions

___1. None
___2. Skilled Nursing Facility
___3. Extended Care Facility
___4. Psychiatric Inpatient Facility
___5. Respiratory Isolation
___6. Other:

B. Transportation

___ 1. Routine
___ 2. Crutches/Cane
___ 3. Ambulance
___ 4. Wheelchair/Wheelchair Van
___5. Prosthesis: _____

C. Pending Specialty Clinic Appointment
None _____ Type _____

D. ALLERGIES _____
_____
_____

NKA _____

B. Preventive Medicine

___ 1. Tuberculosis Status
Skin Test: Date Given: ___/___/___ Date Read: ___/___/___ Results _____mm*
X-Ray: Date: ___/___/___ Normal ___ Abnormal ___* Anti-TB Treatment? No ___ Yes ___*
___ 2. Hepatitis: A __ B __ C __ Other: _____
___ 3. HIV Antibody: Test Date: ___/___/___ Results: Neg _____ Pos _____ CD4: ____ Date __/__/__
___ 4. Syphilis: Date: __/__/__ Type: ____ Treatment Completed: ____Yes ___No

NOTE: If any treatment has been recommended, the X-Ray was abnormal, or skin test indicates infection please attach tuberculosis record.

C. Other Health Care Problems: _____

IV. CURRENT PRESCRIBED MEDICATIONS None _____

Medication	Dosage	Frequency

THIS FORM MUST ACCOMPANY ALL OFFENDERS TRANSFERRED TO AND FROM ALL TEXAS CRIMINAL JUSTICE ENTITIES

COMPLETED BY: _____ DATE: _____/_____/_____
Signature/Title
PHONE NUMBER: _____ FACILITY: _____

INSTRUCTIONS

THIS FORM MUST ACCOMPANY ALL OFFENDERS TRANSFERRED TO AND FROM ALL TEXAS CRIMINAL JUSTICE ENTITIES

I. Print the inmate patient=s name, date of birth, age, state identification number, race, weight (WT) and height (HT). Place a check mark in the appropriate space for sex and record your respective facility identification number on the County/TDCJ#. (Note: this number should be the internal number used by the different counties) Last: Has inmate's name been cross-referenced with the MH/MR database (CARE) for prior or current service status?

II. A. **Health Problems** - Indicate the inmate=s response (YES, NO) to having been treated by placing a check mark in the applicable space.

1. **NONE** - The inmate patient states he/she has no known medical problems and none were detected during the physical examination.
2. **ASTHMA** - A sudden attack of shortness of breath accompanied by wheezing, caused by a spasm of the airway or swelling in the airway.
3. **PREGNANCY** - Does the inmate suspect she may be pregnant?
4. **DENTAL PRIORITY** - Any dental problems the inmate claims need attention.
5. **DIABETES** - Taking insulin or other medication to control the sugar level in the blood.

6/7. **DRUG ABUSE/ALCOHOLISM** - Dependence on drugs and/or alcohol.

8. **ORTHOPEDIC PROBLEMS** - Chronic joint complaints or recent fracture.
9. **CARDIOVASCULAR/HEART TROUBLE** - Coronary artery disease, heart attack, angina pectoris, and congestive heart failure are all examples.
10. **SUICIDAL** – Has expressed suicidal thoughts, or attempted suicide.
11. **MENTAL RETARDATION** - Has inmate been diagnosed as mentally retarded?
12. **MENTAL ILLNESS** - Has the inmate been treated by a psychologist or psychiatrist or has a doctor ever treated him for a mental health problem?
13. **RECENT SURGERY** - Any surgery within the past 30 days, explain in II-C.
14. **SEIZURES** - Sudden uncontrollable muscle spasm or unconsciousness.
15. **DIALYSIS** - Does the inmate patient have renal failure and in need of dialysis treatment?
16. **HYPERTENSION (HIGH BLOOD PRESSURE)** - Treated with drugs or diet.
17. **CARE SYSTEM –** Inmate's name has been submitted to local MHMR and has a prior or current service status. (yes/no)

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B. **Preventive Medicine**

1. Please indicate date of last TB skin test, including date read and results in mm of reaction, if any. If no reaction, indicate 0.
2. Please indicate whether patient has infection with hepatitis A,B, or C by checking the appropriate box.
3. Please indicate date of last HIV antibody test and results. If positive, indicate last CD4 count.
4. Please indicate last syphilis test, if positive. Indicate whether treatment was complete or not.

C. Does the inmate have any condition that might indicate the need for medical care? Body deformities, swelling, open wounds, skin discoloration, rashes, needle marks, severe dental problems, or bruises are all examples of things to note that were not listed in sections IIA or IIB.

III. A. **Housing Restrictions**

1. **NONE**
2. **SKILLED NURSING FACILITY** - Does the inmate have a temporary medical problem requiring inpatient nursing care?
3. **EXTENDED CARE FACILITY** - Does the inmate have a permanent medical problem requiring long-term inpatient nursing care?
4. **PSYCHIATRIC INPATIENT FACILITY** - Is the inmate in need of crisis management or is he/she currently admitted to a psychiatric inpatient facility?
5. **RESPIRATORY ISOLATION** - Does the inmate have a current diagnosis of ACTIVE TB or other active disease such as chicken pox or measles?
6. **OTHER**

B. **Transportation** - Does the inmate require any of the following to walk distances greater than 25 yards? If not please check the routine space.

1. ROUTINE
2. CRUTCHES/CANE
3. AMBULANCE
4. WHEELCHAIR/WHEELCHAIR VAN
5. PROSTHESIS

C. List any pending specialty clinic appointments the inmate patient had upon transfer from your facility. Please list any scheduled specialist appointments the inmate may have.

IV. List known medications. Please list all currently ordered life sustaining medications. You may omit over the counter medications.

V. List any known allergies.