PE-02 MEDICAL & BEHAVIORAL HEALTH ADMISSION SCREENING:

Inmate Name:	Facility:	ID#:	DOB:	Today's Date

Pre-Booking Healthcare Screen completed? **Yes/No**
Booking Date: _____ Booking Time: _____

Is an interpreter needed to complete intake? **YES/NO**
If yes, Name of interpreter: _____ Language Needed: _____

DOES PATIENT HAVE MEDICAL/MH PROBLEMS NEEDING IMMEDIATE ATTENTION? Yes/No
If yes, what is the problem? _____
RACE: _____

COVID- 19 SCREENING:

1. Assess the Risk of Exposure - Have you...
   Traveled to Vermont from one of the affected countries listed at healthvermont.gov/covid19 (Currently most of Europe, China, Iran, and South Korea? **YES/NO**
   Been in contact with a novel coronavirus (COVID-19) infected person? **YES/NO**
2. Assess for Signs or Symptoms of Illness
   Do you have a ... Fever? Cough? Shortness of Breath? GI Symptoms? Chills? Muscle Pain? Headaches? Sore Throat? Loss of taste or smell? Other Symptoms? **YES/NO**
3. Does patient have any risk or symptoms? **YES/NO**
4. Provider contacted? **YES/NO**
5. Have you ever previously tested positive for COVID-19? **YES/NO** (If yes, have pt. sign ROI)
6. Where did you have testing done? (Clinic/Doctors Office/Hospital): _____
7. When did you test positive? _____
8. Date Reported previous positive test? _____
9. Has patient previously been vaccinated for COVID-19? **YES/NO** (If yes, have pt. sign ROI)
   If yes, Moderna/Pfizer/Janssen/Other: _____ 1st/2nd shot, Booster.

9a. Where was vaccine given? (Clinic/Hospital/Doctors Office): _____
10. Has vaccine series been completed? **YES/NO**

VITAL SIGNS/ALLERGIES/BAC:

Weight- lbs.	Height- Ft./In.	BMI- SA/BSA	Blood Pressure/ mmHg	Temperature °C/ °F	Pulse/ HR minute	Respirations per minute	Pulse Oxygen %	BAC

ALLERGIES: Does the patient have allergies? **YES/NO** If yes, list below:

Medication/Food/Environmental	Reaction

INSURANCE:
Does patient have insurance? **YES/NO** If yes, Type: _____

ENTITLEMENTS:
Does patient receive any of the following: Medicaid, Medicare, SSI, SSDI, Health Care Insurance (If yes, Specify)? **YES/NO/NONE** _____

PE-02 MEDICAL & BEHAVIORAL HEALTH ADMISSION SCREENING:

DOES PATIENT HAVE A MOBILITY/VISION/HEARING/MH DISABILITY? Yes/No

List the type of ADA needed (glasses, hearing aids, headphones, CPAP machine, Bottom Bunk, Bottom Tier, W/C, etc.): _____

CHRONIC MEDICAL PROBLEMS:

Does patient have any chronic medical conditions? **YES/NO**

Other chronic conditions not listed below:

__**Asthma**- How long has patient been diagnosed with Asthma? ____years; Ever been hospitalized for asthma? Yes/No; If yes, when: _____Where: ____ Currently prescribed an inhaler? Yes/No; Currently on steroids? Yes/No

__**Diabetes**- How long? ____years; Currently taking medication for diabetes? Yes/No; If yes, what? _____ Does pt. take Insulin? Yes/No; Previous hospitalization? Yes/No if yes, where/when: _____ If fingerstick >300: Nausea? Vomiting? Excessive Thirst? Urine Ketones?

__**Cardiovascular**- Does pt. have chest pain? Yes/No; Stents? Yes/No; Previous heart attack? Yes/No; Atrial Fibrillation? Yes/No; Pacemaker? Yes/No; Internal Defibrillation? Yes/No; Endocarditis? Yes/No; Blood Clots in in lungs or legs? Yes/No; Taking Warfarin/Coumadin or another blood thinner? Yes/No; Last episode? _____

__**Cerebrovascular Disease**- Has patient ever had a CVA (stroke)? Yes/No; TIA? If any are yes, when?

__**Hypertension**- How long has pt. been dx w/HTN? ____ Currently on medications? Yes/No Three or more anti-hypertensives? Yes/No.

__**Epilepsy/Seizure**- Last seizure? _____More than one seizure a month? Yes/No; Two or more anticonvulsants? Yes/No.

__**Gastrointestinal**- Ever vomited blood? Yes/No If yes, last time: _____. Ever had black stools from bleeding? Yes/No If yes, when: _____

__**Cancer**- Do you currently have cancer? Yes/No; Are you currently being treated for cancer? Yes/No If yes, type: _____ Have you had cancer previously? Yes/No If yes, type: _____ Date of last treatment: _____

__**Dialysis**- Which type do you have? Hemodialysis/Peritoneal; How many times a week? _____; Last dialysis? _____

__**COPD/Emphysema**- o2 dependent? Yes/No; Peak flow: _____; Current medications? Yes/No

__**Hepatitis**- Which type? HAV/HBV/HCV; Have you been treated for HCV? Yes/No.

__**HIV/AIDS**- Are you on medications? Yes/No, If yes, when was the last lab drawn? _____

__**STD**- What type of STD/STI do you have? _____

__**Other Infectious Diseases**- _____

__**Other chronic disease/problem** not listed above: _____

FEMALE QUESTIONS:

Date of last menstrual period: _____

Is she currently pregnant? **YES/NO** If yes, **EDD: _____**

Has pregnancy test been completed? **YES/NO** If completed are test results: **Positive/Negative**.

PRENATAL CARE:

If pregnant has patient been seen by outside provider for OB/GYN care prior to incarceration? **YES/NO**; If yes,

Name of Provider/Clinic/Center Seen	Town Located:	Estimated Due date if known

Has patient given birth in the last 90 days? **YES/NO**; If yes,

Provider Name	Type of Provider	Name of Clinic/Hospital	Town located

Is she currently lactating? **YES/NO**

PE-02 MEDICAL & BEHAVIORAL HEALTH ADMISSION SCREENING:

MEDICATIONS:

Is s/he currently prescribed medications? YES/NO

If yes, complete Medication Verification Form.

Medication Name	Dose/Frequency/Duration	Pharmacy	Last Dose Taken

MAT MEDICATIONS:

Is s/he prescribed MAT medications? **YES/NO** (If yes, sign ROI for HUB/Clinic/Dr.'s Office)

MAT Provider/ Clinic Name:	Medication Name	Dose/Frequency/ Duration	Pharmacy/Clinic pick Rx up at:	Last Dose taken	Signed MAT agreement?
					Yes/No

If yes, will need to have MAT paperwork and Consent forms completed.

SMOKING HISTORY:

1. Which statements best describe your current tobacco use? *(Choose all that apply):*

__ I have never smoked cigarettes (Mark here if you only tried smoking) *Skip to question 9*

__I stopped smoking w/in the last year – I am not smoking. *Skip to question 9*

__I dip, chew, or use smokeless tobacco.

__I smoke e-cigarettes/vapor.

__I smoke regularly now. # of cigarettes I smoked yesterday___

2. How long have you used tobacco (for nicotine products – say which product and for how long)? _____
3. Are there any changes in your use of tobacco *(or nicotine products)* recently? **YES/NO**
   If yes, increased/decreased use.
4. How soon after you wake up do you usually use tobacco? *(choose only 1)*
   __ 5 minutes or less __6-30 minutes __31-59 minutes __1-2 hours __Greater than 2 hours
5. How many attempts to quit have you made: ___
   Date of your most recent quit attempt: _____
   How long were you able to stay quit? _____
6. If you have tried quitting before what worked to help you? _____
   What have you tried that did not work? _____
   What were the reasons you went back to smoking? _____
7. Have you ever tried using nicotine replacement products? **YES/NO**
   If yes, what product(s) _____; How much did you use: _____
   For how long did you use it? _____
8. How ready do you feel now to quit*: A). not thinking about it. B). Thinking about it, not ready. C). Ready to quit (if ready, how confident do you feel about your ability to quit on 1-10 with 1 being low:* _____
9. How many cigarette smokers live in the same house with you? *(Choose only one)*
   a. None b. 1 c. 2 or more
10. How is cigarette smoking handled where you live? *(Choose only one) a).no one smokes where I live-they smoke outside. b). People may only smoke in certain rooms where I live. c). People may smoke anywhere I live. d). Don't know. E). Refuse to say.*
11. How many of your family and friends are cigarette smokers? *(Choose only one) a). None b). A few c). Some d). Most*

Peak Flow Reading:

PE-02 MEDICAL & BEHAVIORAL HEALTH ADMISSION SCREENING:

TB & COMMUNICABLE DISEASE SCREENING:

Is the patient HIV positive? **YES/NO**

If yes, and has hx of +PPD, place order for CXR.

Has patient had any of the following in the last year:

Exposure to TB patient? Coughing up blood? Productive or Persistent cough lasting longer than 3 weeks? Pain in the chest? Reoccurring shortness of breath> Weakness/lethargy? Loss of appetite? Unintentional weightless? Persistent fever (0ver 100 degrees F) Chills or night sweats for no known reason? Any other symptoms? **YES/NO**

If yes, list symptoms reported: _____

Does patient want HIV or HCV testing? **YES/NO** *(select one if applicable):* Both/HIV/HCV

MMR VACCINATION:

Has patient received MMR Vaccine? **YES/NO/UNKNOWN**

Has Patient had two vaccines? **YES/NO/UNKNOWN**

Date of MMR Vaccine if known: _____/**Unknown**.

Has patient visited endemic areas? **NO/YES**

Has patient traveled outside of the US? **NO/YES**

Does patient need to be seen by provider regarding MMR vaccination? **NO/YES.**

DENTAL SCREENING:

Patient reports dental problems: **YES/NO**

Does patient have any dental pain? **YES/NO – (**If yes create nurse referral)

If yes, when did the pain start? (# of days/months ago)	Where is the pain located? (Upper, Lower, Front, Back, Left, Right)	What is the current pain scale from 1-10?	Does the patient have any of the following: Discomfort, Drainage, Lesions, Swelling, Dentures, Partial Dentures?

DIETARY REQUIREMENTS:

Does patient report that he/she needs a special diet due to medical reasons or food allergy? **YES/NO**

Diet Type requested: Prenatal, Heart Healthy, Allergy/Other: _____ If reported food allergy, will need RAST testing to verify.

OBSERVATIONS:

Body Movement: Unimpaired. Abnormal. Body Deformities. Gait Problems.

Appearance: Sweating. Tremors. Poor Hygiene. Disheveled. Pale. Appropriate.

Are there any signs of fever, swollen lymph nodes, jaundice or infection that might spread? **YES/NO**

Skin Exam: Negative observation. Lesions, Jaundice., Rashes. Bed Bugs Scabies, Tattoos. Bruises / Other Signs of Trauma. Scars. Needle marks / Other signs of drug use.

Does patient have any of the following? Bruise(s); Contusions/Redness; Laceration(s); Incision(s), Soreness; Swelling; **YES/NO** If yes, location: _____

Is there evidence of poor skin condition, to include: Deformities (skin or extremities), Ectoparasites, Rashes, Needle marks, Scars, Tattoos, or piercings? **YES/NO**

Behavior/Activity: Uncooperative. Agitated. Angry. Flat. Swearing. Cooperative and Appropriate. Disorderly.

State of Consciousness: Alert. Disoriented (day/date/time) Disoriented. Lethargic. Confused. Has difficulty focusing. Alert and Oriented x 3.

Breathing: Unlabored. Frequent cough. Rapid/abnormal. Lung sounds clear. Persistent cough. Hyperventilation.

Other/Comments: _____

PE-02 MEDICAL & BEHAVIORAL HEALTH ADMISSION SCREENING:

OUTSIDE MEDICAL PROVIDER:

Does he/she have a primary care provider? **YES/NO**

If yes,

Provider/Clinic/Center Name	Town Located

RECENT MEDICAL HOSPITALIZATION:

Was patient hospitalized with in the last year for medical reasons? **YES/NO**

If yes,

Hospital	Town Located	Reason for Hospitalization	Type of Provider

RECENT MENTAL HEALTH HOSPITALIZATION:

Has he/she been hospitalized w/in the last year for mental health reasons? **YES/NO**

If yes,

Hospital	Reason for hospitalization	Town Located

ADDITIONAL PROVIDERS/CLINIC SEEN:

Has he/she seen any other medical/mental health/MAT providers not listed above? **YES/NO**

If yes,

Provider Name	Type of Provider	Name of Clinic/Center	Type of clinic	Town Located

Have you ever been diagnosed with a MH illness, such as Depression, Anxiety, ADHD, or any other MH Illness?
YES/NO *If yes, describe:* _____

SUBSTANCE ABUSE ADMISSION SCREENING:

Has patient used street drugs/meds not prescribed by a doctor? **YES /NO**

Is patient currently detoxing or at risk for detox? **YES/NO**

Explain current Detox (Drug taken/Detox symptoms): _____

Have you ever experienced problems or withdrawal after stopping the use of alcohol or other substances?
YES/NO

Description of withdrawal problems: *Seizures Black-outs Seizures and black-outs Nausea Vomiting Diarrhea Shakes/Tremors Hallucinations-Auditory Hallucinations-Visual Increased agitation Increased anxiety Chills Body Aches*

Does patient drink alcohol? **YES/NO**

Have you ever mis-used alcohol? **YES/NO**

Type of Alcohol/Amount consumed	Last Use

Have you ever misused prescription medication or used illicit drugs/substances? **YES/NO**

Type of Rx/Drug/Substance & Amount consumed	Last Use

SUBSTANCE ABUSE SCREENING OBSERVATIONS:

Does patient appear to be under the influence of alcohol or other substances? YES/NO

Explain: (what did they take, symptoms): _____

Does patient have visible signs of alcohol/drug/substance withdrawal? YES/NO

Patient displays the following: (extreme perspiration, pinpoint pupils, tremors, anxiety, nausea, abdominal cramping, vomiting etc.): _____

_____

PE-02 MEDICAL & BEHAVIORAL HEALTH ADMISSION SCREENING:

TCU DRUG SCREEN:

(During the past 12 months (before incarceration, if applicable):

1. Did you use larger amounts of drugs or use them for a longer time than you planned? YES/NO
2. Did you try to control or cut down on your drug use but were unable to do it? YES/NO
3. Did you spend a lot of time getting drugs, using them, or recovering from their use? YES/NO
4. Did you have a strong desire or urge to use drugs? YES/NO
5. Did you get so high or sick from using drugs that it kept you from working, going to school, or caring for children? YES/NO
6. Did you continue using drugs even when it led to social or interpersonal problems? YES/NO
7. Did you spend less time at work, school or with friends because of your drug use? YES/NO
8. Did you use drugs that put you or others in physical danger? YES/NO
9. Did you continue using drugs even when it was causing you physical or psychological problems? YES/NO
10a. Did you need to increase the amount of a drug you were taking so that you could get the same effects as before? YES/NO
10b. Did using the same amount of a drug lead to it having less of an effect as it did before? YES/NO
11a. Did you get sick or have withdrawal symptoms when you quit or missed taking a drug? YES/NO
11b. Did you ever keep taking a drug to relieve or avoid getting sick or having withdrawal symptoms? YES/NO

What is your drug of choice? _____

12. Which drug caused the most serious problem during the last 12 months? _____

13. How often did you use each type of drug during the last 12 months?

(Options: Never, only a Few times, 1-3 times per month; 1-5 times a week; Daily)

a. Alcohol:
b. Cannaboids-Marijuana:
c, Cannaboids- Hash:
d. Synthetic Marijuana (K2/spice):
E. Opioids- Heroin:
F. Opioids- Opium:
g. Stimulants- Cocaine:
h. Stimulants- Crack:
i. Stimulants- Amphetamines
j. Stimulants- Methamphetamine:
k. Synthetic- Bath salts:
l. Club Drugs: MDMA/GHB/Ecstasy:
m. Dissociative Drugs- Special K:
n. Hallucinogens- LSD/Mushrooms:
o. Inhalants- Paint thinner:
p. Prescription Meds- Depressants:
q. Prescription Meds- Stimulants:
R. Prescription Meds- Opioid pain relievers:
s. Other- Specify:
T. Fentanyl:

14. How many times before now have you ever been in a drug treatment program?
15. How serious do you think your drug problems are?
16. During the last 12 months, how often did you inject drugs with a needle?
17. How important is it for you to get drug treatment now?

TCU Total Score (Total yes responses to questions 1-11b) = _____

Does patient need a referral placed to nursing for positive TCU score with opioids? YES/NO

IF TCU SCORE IS POSITIVE COMPLETE OPIOIDS SUPPLEMENT

OPIOIDS SUPPLEMENT: In the last 12 months…

1. What types of opioids have you used? *Heroin, Oxycodone, Hydrocodone, Morphine, Fentanyl, Hydromorphone, Methadone, Oxymorphone, Codeine*
2. How many times did you inject an opioid? *Never, A few times, 1-3 times a month, 1-5 times per week, Daily*
3. How many times did you take opioids in another way (e.g., ground pills and sniffed it, put a film in your mouth)? *Never, A few times, 1-3 times a month, 1-5 times per week, Daily*
4. How many times did you take an opioid prescribed to you? *Never, A few times, 1-3 times a month, 1-5 times per week, Daily*
5. How many times did you take an opioid prescribed to someone else? *Never, A few times, 1-3 times a month, 1-5 times per week, Daily*
6. From whom did you get the opioids you took? *Medical doctor/Pharmacy/ Family member/ Friend/Someone else (e.g., on the street)*
7. Have you taken opioids for medical reasons? **YES/NO** If yes, describe: _____
8. Have you taken opioids for non-medical reasons? **YES/NO** If yes, describe: _____
9. Has a doctor prescribed opioid medications for you? **YES/NO** If yes, select all applicable: *Most recent Rx filled; Most recent Rx NOT filled; Took all medications as prescribed; Did NOT take all medications as prescribed. Gave or sold any medications to someone else.*
10. Have you taken other medications or illegal drugs for medical reasons (e.g., to treat pain)? **YES/NO** If yes, list drug/medication and reason for taking: _____
11. Do you or someone close to you (e.g., family/friend) have access to naloxone (Narcan) to reverse an overdose? **YES/NO**
12. How many times have you **ever** overdosed after taking opioids? *Never, A few times, 1-3 times a month, 1-5 times per week, Daily*
13. In the past 12 months, how many times have you overdosed after taking opioids? *Never, Once, Twice, 3 times, 4 or more times.*

13a. If you responded to overdose as "*more than Never*," in the past 12 months, what types of opioids did you use? *Heroin, Oxycodone, Hydrocodone, Morphine, Fentanyl, Hydromorphone, Methadone, Oxymorphone, Codeine*

13b. How many times have you gone to the hospital or emergency room because of an overdose on opioids? *Never, Once, Twice, 3 times, 4 or more times.*

13c. How many times where you given naloxone (Narcan) because of an overdose? *Never, Once, Twice, 3 times, 4 or more times.*

13d. Have you received any follow-up treatment after the most recent overdose? **YES/NO** or **n/a**

14. Have you received medication assisted treatment (MAT) in the last 12 months? **YES/NO**
15. Are you currently receiving medication assisted treatment? **YES/NO** If yes, which type? Buprenorphine, Methadone, Naltrexone, Vivitrol
16. Have you obtained any MAT Rx's w/o a prescription? **YES/NO**
17. Have you taken more MAT Rx's than were prescribed? **YES/NO**
18. Have you ever received Substance Abuse Treatment? **YES/NO** If yes, Where and When: _____

Would patient like to be considered for MAT? **YES/NO**

H.E.L.P.S. SCREENING:

H. Have you ever hit your head or been hit in the head? **YES/NO**

E. Have you ever been seen in the emergency room/providers/clinic for a head injury? **YES/NO**

L. Did you lose consciousness? **YES/NO**

P. Did you have any problems after you were hit? **YES/NO** or N/A.

If yes, describe: Poor Judgement (arrests, fights), Poor problem solving, Difficulty reading, writing, or calculating, Change in relationships with others, Difficulty performing your job/schoolwork; Headaches; Difficulty Concentrating; Dizziness; Anxiety; Difficulty Remembering; Depression.

S. Any other significant illness? **YES/NO**

HELPS score: ____ ***Screening is considered POSITIVE ONLY IF answers "Yes" to H/E or S and "Yes" to L/E and has 2 or MORE problems listed under P.*

HELPS Screen positive? **YES/NO** ***If yes, schedule patient to discuss with medical provider.*

PE-02 MEDICAL & BEHAVIORAL HEALTH ADMISSION SCREENING:

If went to hospital/medical provider need the following to send ROI:

Hospital/Medical Provider Seen for Head Injury	Town Located

PREA SCREENING:

1. "While incarcerated, have you been the victim of unwelcome sexual activity? Have you ever been approached for sex or been a victim of sexual assault while incarcerated?" **YES/NO**
2. "Has another inmate ever threatened you with sexual violence? Are you concerned about being sexually assaulted or abused while incarcerated?" **YES/NO**
3. "Are you concerned about your ability to defend yourself here?" **YES/ NO**
4. "Do you have a history of sexual or violent convictions?" **YES/NO**
5. "Have you ever been diagnosed with Gender Dysphoria?" **YES/NO**
6. "Do you identify as transgender, gender variant, or are you transitioning?" **YES/NO**
7. "Does the individual express that they are, or perceived to be any of the following: Developmentally Disordered; Unable to protect themselves in jail; Picked on or bullied by other individuals; Vulnerable (small in stature, frail, or youthful appearing) or other?" **YES/NO**
8. Does an order need to be submitted for CSSRS assessment? **YES/NO**

COLUMBIA-SUICIDE SEVERITY RATING SCALE:

1. Have you wished you were dead or wished you could go to sleep and not wake up? **YES/NO**
2. Have you actually had any thoughts of killing yourself? **YES/NO** *If patient responded no, skip to question 6.*
3. In the past month, have you been thinking about how you might do this? **YES/NO**
4. In the past month, have you had these thoughts and had some intention of acting on them? **YES/NO**
5. In the past month, have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan? **YES/NO**
6. In your lifetime, have you ever done anything, started to do anything, or prepared to do anything to end your life? **YES/NO** If yes, was it within the last 3 months? **YES/NO**

CSSRS SCORING: (Choose one)

__If yes to only question 1 – YELLOW – *Place referral to MH.*

__If yes to only question 2 and no to 3-6 = YELLOW – *Place referral to MH.*

__If yes to question 3 or 6 (6 is w/in lifetime, not past 3 months) – **ORANGE** – *Place on Close Obs. 15 mi. Checks*

__If yes to question 4,5 or 6 (6 if w/in 3 months ago or less) – **RED** –*Place on Constant Obs.*

__Negative

BEHAVIORAL HEALTH RISK ASSESSMENT:

01. Observation of any concerning behaviors? YES/NO If yes, describe: _____

02. Are your charges related to murder, sexual offense, or child molestation? YES/NO if yes, circle which one.

03. Have you tried to attempt suicide in the past? YES/NO If yes, when was the last time? How did you attempt?

_____

04. Do you currently engage in self-harming behaviors? YES/NO

05. Have you recently experienced a significant loss (relationship, death of a family member/close friend)? YES/NO

06. Do you hold a position of respect in the community and/or charged with a high profile/highly publicized crime? YES/NO

07. Is this individual a Juvenile (17 years old or younger)? YES/NO

08. Do you currently receive treatment by a psychiatrist or MH provider? YES/NO

09. Have you received treatment/hospitalized by a psychiatrist or MH provider in the past? YES/NO

10. Is this your first incarceration? YES/NO

11. Do you have an intellectual disability? YES/NO

12. Have you ever received special education services while in school? YES/NO

13. Do you have a family member who has attempted or committed suicide? YES/NO

14. Have you experienced recent physical/sexual/emotional abuse? YES/NO

***NOTE: Any yes response to question #1 = Constant Watch with DOC, call MHC for MH Assessment; Yes, response to questions 2-10 = place on 15-minute checks with DOC, contact MHC for disposition. Yes for 11-14 Routine MH referral to be placed.*

CORRECTIONAL MENTAL HEALTH SCREEN for MEN:

1. Have you ever had worries that you just can't get rid of? **Yes, No, Declined, Don't know**.
2. Some people find their mood changes frequently as if they spend every day on an emotional roller coaster? **Yes, No, Declined, Don't know**.
3. Do you get annoyed when friends or family complain about their problems? Or do people complain that you're not sympathetic to their problems? **Yes, No, Declined, Don't know**.
4. Have you ever felt like you didn't have any feelings, or felt distant or cut off from other people or from your surroundings? **Yes, No, Declined, Don't know**.
5. Has there ever been a time when you felt so irritable that you found yourself shouting at people or starting fights or arguments? **Yes, No, Declined, Don't know**.
6. Do you often get in trouble at work or with friends because you act excited at first but then lose interest in projects and don't follow through? **Yes, No, Declined, Don't know**.
7. Do you tend to hold grudges or give people the silent treatment for days at a time? **Yes, No, Declined, Don't know.**
8. Have you ever tried to avoid reminders, or to not think about something terrible that you experienced or witnessed? **Yes, No, Declined, Don't know.**
9. Has there ever been a time when you felt depressed most of the day for at least 2 weeks? **Yes, No, Declined, Don't know.**
10. Have you ever been troubled by repeated thoughts, feelings, or nightmares about something you experienced or witnessed? **Yes, No, Declined, Don't know**.
11. Have you ever been in a hospital for non-medical reasons such as in a psychiatric hospital? (Do NOT include going to an ER if you were not hospitalized?) **Yes, No, Declined, Don't Know**.
12. Have you ever felt constantly on guard or watchful even when you didn't need to, or felt jumpy and easily startled? **Yes, No, Declined, Don't know**.
    **Enter any information that is relevant and significant from screening or general comments regarding screening/patient i.e., intoxicated, impaired, uncooperative…

    _____

    _____

***NOTE: Answering "Yes" to 6 or more questions should be referred for routine MH Eval. A referral also may be made if the staff person has any concerns about the pts mental status/ability to cope emotionally/ behaviorally. An urgent referral to be placed if there is any behavioral/other evidence that a pt is unable to cope/is a suicide risk. IF AT ANY POINT during questioning the pt experiences more than mild or temporary emotional distress (Such as severe anxiety, grief, anger, or disorientation) she should be referred for IMMEDIATE MH Eval.*

PE-02 MEDICAL & BEHAVIORAL HEALTH ADMISSION SCREENING:

CORRECTIONAL MENTAL HEALTH SCREEN for WOMEN:

1. Do you get annoyed when friends and family complain about their problems or do people complain you are not sympathetic to their problems? **Yes, No, Declined, Don't know**.
2. Have you ever tried to avoid reminders of, or to not think about something terrible that you experienced or witnessed? **Yes, No, Declined, Don't know**.
3. Some people find their mood changes frequently – as if they spend every day on an emotional rollercoaster. For example, switching from feeling angry to depressed to anxious many times a day. Does this sound like you? **Yes, No, Declined, Don't know**.
4. Have there ever been a few weeks when you felt you were useless, sinful, or guilty? **Yes, No, Declined, Don't know.**
5. Has there ever been a time when you felt depressed most of the day for at least 2 weeks? **Yes, No, Declined, Don't Know.**
6. Do you find that most people will take advantage of you if you let them know too much about you? **Yes, No, Declined, Don't know.**
7. Have you been troubled by repeated thoughts, feelings, or nightmares about something terrible that you experienced or witnessed? **Yes, No, Declined, Don't know**.
8. Have you ever been in the hospital for non-medical reasons, such as a psychiatric hospital? (Do NOT include going to an ER if you were not hospitalized) **Yes, No, Declined, Don't know**.
   ** Enter any information that is relevant and significant from screening or general comments regarding screening/patient i.e., intoxicated, impaired, uncooperative… _____
   _____

***NOTE: Answering "Yes" to 5 or more questions should be referred for routine MH Eval. A referral also may be made if the staff person has any concerns about the pts mental status/ability to cope emotionally/ behaviorally. An urgent referral to be placed if there is any behavioral/other evidence that a pt is unable to cope/is a suicide risk. IF AT ANY POINT during questioning the pt experiences more than mild or temporary emotional distress (Such as severe anxiety, grief, anger, or disorientation) she should be referred for IMMEDIATE MH Eval.*

MH Referrals: *(Circle one):* Emergent referral Urgent referral Routine referral

ADVANCED DIRECTIVE:

Is patient interested in completing Advanced Directive's? **YES/NO** *If no, refusal from needs to be completed.*

MEDICAL DISPOSITION CHANGE REQUEST:

Type of request: *Medical*

M- Code:

M1- No medical/MH/Dental issues/Rx's, no upcoming appointments
M2- Rx's, Chronic Illnesses/Diseases, Has a medical/MH/Dental problem
M3-MAT Rx; Pregnant; Upcoming outside appts; SFI; Needs provider order to move between facilities.
M4-Cannot move from facility, Suicide Watch.

Reason for request: _____

Disposition:

__General population __Isolation __Infirmary __Immediate Referral to Medical Provider.
__Immediate Referral to MH Provider.

GUARDIANSHIP APPOINTED/DURABLE POWER OF ATTORNEY:

Does patient have a guardian appointed or a durable power of attorney? **Yes/No**

FLU VACCINE:

Would patient like to be given the Flu vaccine? **YES/NO**

COVID-19 Vaccine:
Would patient like to be given the COVID-19 vaccination? **YES/NO** *Initial/Second/1st Booster/ 2nd Booster.*

PATIENT EDUCATION HANDOUTS/FORMS:
Does the patient need any of the following educational handouts?
Abrasion; Diabetes; Diarrhea; Headaches; Insect bite/sting; Laceration; Lice; Pepper Spray Exposure; Rash; Scabies; Seizures; Skin Infection; Sprains, Strains, and Minor Trauma; Taser exposure; Use of force; Vomiting; HTN; How to do self-Breast exams; What is Prenatal care, Request for Reasonable Accommodations, MAT Orientation Paperwork; MAT Pt. Agreement; Medical Diet Service Agreement; VCMAT Orientation Packet

EDUCATIONAL FORMS THAT NEED TO BE CREATED:
The following will be created for patient to review/sign at intake:
Inmate Guide to Health Services
Patient Guide to Medical Services
Blood Borne Pathogens education.
Patient Information on Discharge
Sexual Assault Awareness Education
ADA Orientation
How to Brush
Patient Information on Discharge
VITL Opt-Out Form
Green Mtn. Care Application
HIV Oral Screening
Agreement to not misuse medications.
Informed Consent for FLU Vaccine as well as Vaccination Information Sheet
Informed Consent for MAT Medication
Informed Consent for Telehealth
Medication Verification Form (one for each different pharmacy)
Release of Information (one for each provider/clinic/hospital)
Patient Discharge Questionnaire
Patient MAT Medical Need Questionnaire

DO ANY OF THE FOLLOWING ACTIONS NEED TO BE TAKEN?
Segregation Housing Order
COVID-19 Daily Screening
Medical Chart Review- (Only if they have been released less than 90 days)
MH Chart Review
Bottom Bunk pass due to detox/medical reasons- only able to give temporary 7-day pass.
Initial Health Assessment
Initial Chronic Disease Clinic Visit
Initial MAT Provider Visit
Eye Exam
Flu Vaccine Order
COVID-19 Vaccine Order
Positive HELPS Screening Visit with Medical Provider
Positive TCU w/opioids-Nurse Visit
Nurse Visit due to dental pain.
PPD Plant
Detox Orders – COWS/CIWA-Ar/CIWA-B

PE-02 MEDICAL & BEHAVIORAL HEALTH ADMISSION SCREENING:

ALL NEW INTAKES MUST HAVE THE FOLLOWING ORDERS CREATED:

New Female/Male Intake Urinalysis Order; Initial Health Assessment; Initial Dental Exam; Routine MH Evaluation; PPD Plant

I have answered all questions truthfully. I have been given verbal and/or written information on how to access healthcare services, and how to report my complaints about healthcare issues. I consent to routine medical, mental health and dental services. I consent to have baseline labs ordered/performed for my initial visit with the medical provider.

Inmate Signature_____ Date: _____

Staff Signature/Title: _____ Date/Time: _____