

Medical Screening

Report Date/Time:

Last Name:

Intake Officer:

First Name:

Screening Date/Time:

Reg. Date/Time:

Screening Decision:

Registration #:

Medical Officer:

Screening Questions/Comments

Answers

1. If Female, pregnant?	YES / NO
Comment:	
2. Have you had a serious injury/hospitalization in last 90 days?	YES / NO
Comment:	
3. Are you currently taking any prescription medicine?	YES / NO
Comment:	
4. Any disability/chronic illness (diabetes, hypertension, etc.)?	YES / NO
Comment:	
5. Does inmate appear to be under the influence of alcohol or drugs?	YES / NO
Comment:	
6. Do you have a history of drug/alcohol abuse?	YES / NO
Comment:	
7. Do you think you will have withdrawal symptoms from stopping use of medications or other substances (including alcohol or drugs) while you are in jail?	YES / NO
Comment:	
8. Have you ever had a traumatic brain injury, concussion, or loss of consciousness?	YES / NO
Comment:	
9. Is the inmate unable to answer questions? If yes, note why, notify supervisor and place on suicide watch until form is completed.	YES / NO
Comment:	
10. Does the arresting/transporting officer believe or has the officer received information that inmate may be at risk of suicide?	YES / NO
Comment:	
11. Are you thinking of killing or injuring yourself today? If so, how?	YES / NO
Comment:	
12. Have you ever attempted suicide? If so, when and how?	YES / NO
Comment:	
13. Are you feeling hopeless or have nothing to look forward to?	YES / NO
Comment:	
14. Do you hear any noises, or voices other people don't seem to hear?	YES / NO
Comment:	
15. Do you currently believe that someone can control your mind or that other people can know your thoughts or read your mind?	YES / NO
Comment:	
16. Prior to arrest, did you feel down, depressed, or have little interest or pleasure in doing things?	YES / NO
Comment:	
17. Do you have nightmares, flashbacks or repeated thoughts or feelings related to PTSD or something terrible from your past?	YES / NO
Comment:	
18. Are you worried someone might hurt or kill you? If female, ask if they fear someone close to them.	YES / NO
Comment:	
19. Are you extremely worried you will lose your job, position, spouse, significant other, custody of your children due to arrest?	YES / NO
Comment:	
20. Have you ever received services for emotional or mental health problems?	YES / NO
Comment:	
21. Have you been in a hospital for emotional/mental health in the last year?	YES / NO
Comment:	
22. If yes to 20 or 21, do you know your diagnosis? If no, put "Does not know" in comments.	YES / NO
Comment:	
23. In school, were you ever told by teachers that you had difficulty learning?	YES / NO

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Comment:

24. Have you lost / gained a lot of weight in the last few weeks without trying (at least 5lbs)?

YES / NO

Comment:

25. Does inmate show signs of depression (sadness, irritability, emotional flatness)?

YES / NO

Comment:

26. Does inmate display any unusual behavior, or act or talk strange (cannot focus attention, hearing or seeing things which are not there)?

YES / NO

Comment:

27. Is inmate incoherent, disoriented or showing signs of mental illness?

YES / NO

Comment:

28. Inmate has visible signs of recent self-harm (cuts or ligature marks)?

YES / NO

Comment:

29. Is the prisoner being brought in from a mental hospital?

YES / NO

Comment:

30. Refer prisoner for medical screening prior to transfer of custody?

YES / NO

Comment:

31. When you leave jail will you live on the streets?

YES / NO

Comment:

32. CCQ match or possible CCQ match found?

YES / NO

Comment:

33. Arresting Officer - Was the prisoner involved in a major accident in the last 48 hours?

YES / NO

Comment:

34. Arresting Officer - To your knowledge, does the prisoner have a head, neck, chest or abdominal injury sustained in the last 48 hours?

YES / NO

Comment:

35. Arresting Officer - To your knowledge, has the prisoner ingested a dangerous or unknown substance in the past 48 hours?

YES / NO

Comment:

36. Have you been in close contact with someone diagnosed with COVID-19 in the past 7 days?

YES / NO

Comment:

37. Do you have fever, chills, respiratory symptoms, swollen lymph nodes, new bumps/rash, or sores?

YES / NO

Comment:

38. Do you take insulin?

YES / NO

Comment:

Magistrate and Mental Health Notification - Date/Time (Electronic): _____

Medical Notification - Date/Time: _____

Supervisor Notification - Date/Time: _____