Department of Public Safety & Correctional Services
Sick Call Request/Encounter Form

Date/Time Stamp	Medical Triage: (E) (U) (R) Apply Copay: ☐ Yes ☐ No
Directions: • **Section I: To be completed by incarcerated individual.** • **Section II: To be completed by clinician.** Incarcerated individual must state specific reason for requesting Medical/Dental/Mental Health services.	Signature _____ Date/Time _____ Verification Signature _____ Date/Time _____

Section I: To Be Completed By Incarcerated Individual

Name:	DOB:	SID#:	Cell#:	Facility:
Allergies:			Date:	

Sick Call Request

State your problem. How can we help you? (Please be specific) ☐ Medication not received

_____

_____

_____

A. Where does it hurt?

B. When did it start?

C. Has it happened before? How often?

Non–Sick Call – Healthcare Issues

☐ Medical Records Request ☐ Work Clearance Request ☐ Dental Exam/Filling/Denture Request

☐ Medication Refill ☐ Eye Glass Repair Request ☐ Other: _____

Place Medication Refill Sticker Here	Place Medication Refill Sticker Here	Place Medication Refill Sticker Here	Place Medication Refill Sticker Here

Section II: To Be Completed By Healthcare Personnel

Healthcare Encounter Documented in EPHR: (Comments)

_____ Provider

_____ Date / Time

Sick Call Request / Encounter **(E)** **(U)** **(R)**

Form Forwarded To:

☐ Dental

☐ Mental Health

☐ Medical Records

☐ Other: _____

Date/Time Sent	Date / Time Received
Signature	Signature

Response to the Incarcerated Individual: _____