DEPARTMENT OF PUBLIC SAFETY & CORRECTIONAL SERVICES
SICK CALL REQUEST/ENCOUNTER FORM

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.

MEDICAL TRIAGE: (E) (U) (R)

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 INCARCERATED INDIVIDUAL: