OREGON DEPARTMENT OF CORRECTIONS
Operations Division
Health Services Section Policy and Procedure #P-E-02

SUBJECT: RECEIVING SCREENING

POLICY: Receiving screening is a system of structured inquiry and observation to prevent newly received inmates who pose a threat to their own or others' health and safety from being admitted to the institution general population and to arrange for prompt attention to the inmate's health care needs. Receiving screening is to be conducted in a manner that provides sufficient privacy to elicit pertinent health information without jeopardizing security. Inmates received from other state operated correctional facilities on transfer will have their health record and automated health information reviewed by health services personnel at the receiving facility to determine if the inmate is to be assigned to general population and if there is a need for prompt attention to an identified health problem.

REFERENCE: OAR 291-124-025(2)
NCCHC Standard P-E-02

PROCEDURE:

A. Receiving screening is to be performed immediately upon arrival by a licensed nurse on all inmates at the time they are received at a state-operated correctional facility and findings recorded on an approved form (see attached).

1. The receiving officer will notify the Health Services Unit at the institution at the time inmates are received at the facility.

2. Licensed nursing personnel will either go to the receiving area or have the inmate brought to the Health Services area to conduct the receiving screening before the inmate is assigned to general population.

3. A licensed nurse will interview the inmate completing the Receiving Screening form. Assessment personnel will complete the computerized Mental Health screening.

4. The screening process includes, at a minimum, consideration of information concerning the following areas:

    a. Inquiry into past and current illnesses, health problems and conditions.

1) Past or current history of serious infectious or communicable diseases, any treatment or symptoms suggestive of such illness.
2) Mental illness including suicide risk.
3) Dental problems
4) Allergies
5) Current medications and any other special health requirements (including dietary).
6) Use of alcohol/drugs and any history of associated withdrawal symptoms.
7) For females date of last menstrual period, date of last pap smear, current GYN problems and pregnancy.

b. Additional information is to be elicited from the inmate to any question the inmate answers "yes" to on the History form or if observation during the interview suggests the presence of a health problem.

c. The inmate's behavior and physical status is to be objectively evaluated to include observation of the following:

1) Behavior which includes state of consciousness, mental status (including suicidal ideation), appearance, conduct, tremors, and sweating.
2) Body deformities and ease of movement.
3) Persistent cough or lethargy.
4) Condition of skin, including trauma markings, bruises, lesions, jaundice, rashes, infestations, and needle marks or other indications of drug abuse.

5. If the inmate refuses to answer the interview questions, this is to be documented on the form. If the inmate is unable to answer the questions during the interview, this is to be documented on the form with the reason, if health care personnel are able to ascertain the reason.

6. All inmates will be screened upon admission for Tuberculosis. (Refer to TB Screening Protocol) Inmates identified as possibly having pulmonary tuberculosis disease will be isolated in a negative pressure cell.

7. Upon completion of the interview and objective evaluation, determine the immediate disposition of the inmate to include the options of:

a. the inmate requires health care beyond the capacity of the facility.

b. immediate referral to an appropriate health care service area for further evaluation, observation and/or treatment for medical or mental health issues.

c. release to general population with later referral for further evaluation and/or treatment.

d. no health problems and may be released to general population.

e. special housing requirements.

8. The disposition of the inmate, upon completion of receiving screening, is to be documented on the form (attached), signed, dated and timed by the Health Services personnel conducting the screening. At this time, Health Services personnel enter “critical” health status information into the automated health status information screen on the Offender Information System.

9. The inmate is to be provided with a written and verbal explanation of how to obtain medical attention to include sick call procedures and medication lines.

10. A licensed nurse will activate a medication administration record if necessary and ensure appropriate medications are made available.

11. A licensed nurse will interview and complete the medical history form before the practitioner’s health assessment.

12. Each inmate will be scheduled for a practitioner health assessment within seven (7) days of admission. (Refer to Policy and Procedure #P-E-04, Health Assessment.) Any updates to the automated health status information are completed after the health assessment.

B. Male inmates with a complex medical condition may bypass Coffee Creek Correctional Facility and be admitted directly to another state-operated correctional institution upon direction of a Department of Corrections Health Services Manager, or designee. In these cases, the receiving Department of Corrections institution transfers the inmate directly to the health services area where intake screening is accomplished according to the procedure outlined in Section A above.

Effective Date: ______________
Revision date: April 2007
Supersedes P&P dated: March 2006

OREGON DEPARTMENT OF DEPARTMENT
MEDICAL RECEIVING SCREENING/MEDICAL HISTORY

LEVEL OF CONSCIOUSNESS	MENTAL STATUS	BEHAVIOR	APPEARANCE	SKIN CONDITION
☐Alert	☐Oriented AOx3	☐Cooperative	☐Relaxed	☐Unremarkable
☐Confused	☐Normal Affect	☐Passive	☐Clean/Neat	☐Bruises
☐Agitated	☐Flat Affect	☐Evasive	☐Disheveled	☐Breaks in Skin
	☐Elated	☐Demanding	☐Dirty	☐Rash
GAIT	☐Fearful	☐Angry	☐Body Odor	☐Diaphoretic
☐Normal	☐Hyper vigilant	☐Threatening	☐Tremulous	☐Infestation
☐Limps	☐Hallucinating	☐Combative	☐Body Deformity	☐Needle Marks
☐Staggering	☐Delusional	☐Appears in Pain	☐Prosthetics	☐Lesions
☐Other________	☐Incoherent		☐Poor Dentition	☐Other________

1. Do you have any current illness, injury, or special health requirements? Yes☐ No☐
   Explain:______

2. Do you have any dental problems? Yes☐ No☐
   Explain:______

3. Are you currently on medications? Yes☐ No☐
   Medications:

4. Do you have or have you had any communicable diseases? Yes☐ No☐
   Explain:______

5. Alcohol and drug use: Yes☐ No☐
   Alcohol: Type:______ Amount:______ Last Use:______

   Cigarettes: How much? How Many Years?

Drugs:	Type	Last Used	Mode
	______	______	______
	______	______	______
	______	______	______

6. Have you had serious withdrawal symptoms (seizures, DT's) after stopping drugs or alcohol? Yes☐ No☐
   Explain:______

7. ALLERGIES:______
   Reactions:______

FEMALE INMATE Are you pregnant now? Yes☐ No☐

	Yes	No	Comments
a. PID	☐	☐	______
b. Lumps in Breast	☐	☐	______
c. Menopausal	☐	☐	______
d. Gyn Surgery	Date		
i. Tubal	______		______
ii. Hyst	______		______
iii. Pan Hyst	______		______
iv. C Sect	______		______

Name
SID:
DOB

Pregnancy History

a.	Gravida	______	______
b.	Para	______	______
c.	SAB	______	______
d.	TAB		______
e.	LMP	______	______

Birth Control Method______

MENTAL HEALTH

1. Have you ever been treated for mental health or emotional problems? Yes☐ No☐
   If yes, when, why, & where?______

2. Have you been a medical, mental health or suicide risk during incarceration at DOC facility? Yes☐ No☐
   If yes, explain?______

3. Have you ever been hospitalized for mental illness Yes☐ No☐
   If yes, where and how long?______

4. Have you ever attempted suicide? Yes☐ No☐
   If yes, when, why, & how?______

5. Have you ever considered suicide? Yes☐ No☐
   If yes, when, why, & how?______

6. Has a family member/close friend ever attempted or committed suicide? Yes☐ No☐
   Explain

7. Have you recently experienced a significant loss (relationship, death of family member/close friend, job, etc.?) Yes☐ No☐
   If yes, explain______

8. Do you feel there is nothing to look forward to in the immediate future? (Inmate expressing hopelessness and/or helplessness?) Yes☐ No☐
   If yes, explain______

9. Are you thinking of hurting and/or killing yourself? Yes☐ No☐
   If yes, explain______

10. Was the inmate a medical, mental health or suicide risk during the incarceration in the sending institution, and/or does the transporting office believed that the inmate is a medical, mental health or suicide risk now? Yes☐ No☐
    If yes, explain:______

MEDICAL HISTORY

Check appropriate response. Explain all “yes” answers briefly; e.g. date of occurrence or diagnosis, type and length of treatment or prescriptions.

		YES	NO	COMMENT
1.	Arthritis	☐	☐	______
2.	Eczema/Skin Condition	☐	☐	______
3.	Eye disease/Blindness	☐	☐	______
4.	Thyroid Trouble	☐	☐	______
5.	Heart Trouble	☐	☐	______
6.	High Blood Pressure	☐	☐	______
7.	Emphysema/Asthma	☐	☐	______
8.	Stomach Trouble	☐	☐	______
9.	Hepatitis/Liver Disease	☐	☐	______
10.	Gall Bladder Problem	☐	☐	______
11.	Diabetes	☐	☐	______
12.	Kidney/Bladder Problem	☐	☐	______
13.	Prostate Trouble	☐	☐	______
14.	Rectal Bleeding/Hemorrhoids	☐	☐	______
15.	Epilepsy	☐	☐	______

Name
SID:
DOB

16. Cancer	☐	☐	______
17. Blood Disorder	☐	☐	______
18. HIV	☐	☐	______
19. STD's	☐	☐	______

TRAUMA/ORTHOPEDIC/HOSPITALIZATION
(Significant Only)

Injuries:______

Surgeries:______

Hospitalization:______

IMMUNIZATION HISTORY

Enter date received or N/A

Measles______ Mumps______ Rubella______ Tetanus______

FAMILY HISTORY

Are any or your relative known to have:

	YES	NO	COMMENTS
1. Arthritis	☐	☐	______
2. Allergies	☐	☐	______
3. Anemia	☐	☐	______
4. Bleeding Tendencies	☐	☐	______
5. Cancer	☐	☐	______
6. Diabetes	☐	☐	______
7. Epilepsy	☐	☐	______
8. Heart Trouble	☐	☐	______
9. Mental Illness	☐	☐	______
10. Other Inherited Disease	☐	☐	______

ADDITIONAL INFORMATION

Is there anything else about your health history/status that we should be aware of? Yes☐ No☐

If yes, explain______

Instructed in accessing health care? Yes☐ No☐

If no, why?______

Date /Time Screened:______

Signature:____________________________Date:___________

(Inmate Signature)

Signature:____________________________Date:___________

(Interviewer Signature)

Signature:____________________________Date:___________

(Practitioner Signature)

Name
SID:
DOB