

MONTANA DEPARTMENT OF CORRECTIONS
INTAKE/RECEPTION HEALTH SCREENING FORM

Name: _____ Date & Time Admitted to
A0/JO Number: _____ Intake/Reception: _____
DOB: _____ Date & Time of Screening: _____

Status: _____ Previous Commitment: Yes . No ___ When: _____
Where: _____ County Detention: _____ How Long: _____
Temp: _____ Pulse: _____ Resp: _____ B.P.: _____ Ht: _____ Wt: _____

Visual Observation (explain any "Yes" answers under "Remarks")

- 1. Is offender unconscious or have obvious pain, bleeding, injuries, illness or other symptoms suggesting a need for emergency medical referral? Yes No
2. Is offender carrying any prescribed medication? If Yes, what? Yes No
3. Is there obvious fever or other evidence of infection, e.g., cough, lethargy? Yes
4. Is there evidence of body vermin, rashes, needle marks, jaundice, bruises, trauma marking, lesions, & etc.? Yes No
5. Does offender appear to be under the influence of, or withdrawing from, drugs, alcohol or an unknown substance? Yes No
6. Does offender's behavior or physical appearance suggest the risk of suicide or assault on staff or other offenders? Yes No
7. Is offender's mobility restricted in any way? Yes No
8. Is there any presence of body deformity? Yes No
9. Mental Status: (Circle appropriate status)
a. Level of consciousness (alert, oriented, lethargic, comatose)
b. Appearance and behavior (neatly groomed, disheveled, bizarre, threatening)
c. Speech and Communication (fluent, mute, loud, rambling)
d. Mood and Affect (depressed, flat, euphoric, normal, angry, irritable)
e. Thought Process (normal train of thought, tangential, confused, disorganized)
f. Thought Content (normal, strange or odd belief, suspiciousness, auditory and visual hallucinations present)

Offender Interview (explain any "Yes" answers under "Remarks")

- 1. Present Medication (if none, so state): _____
2. Allergies (if none, so state): _____
3. Ever had: diabetes, seizures, asthma, ulcers, high blood pressure, a heart condition or a psychiatric disorder? Yes No
4. On a special diet prescribed by a physician? Yes No
5. Been hospitalized or treated by a physician within the past year? Yes No
6. Been exposed to or have a contagious or communicable disease (i.e. AIDS, Hepatitis, TB, VD, etc.?) Yes No
7. Fainted recently or had a recent head injury? Yes No
8. Have any dental problems? Yes No
9. Have any other medical or mental problems you have not told me about? Yes No
10. Use alcohol? What kind? _____ How often? _____ Yes No
How much? _____ When was the last time? _____
11. Use drugs? What kind? _____ How often? _____ Yes No
How much? _____ When was the last time? _____
Withdrawal symptoms? _____ Yes No

