TEXAS UNIFORM HEALTH STATUS UPDATE

This form MUST accompany all offenders transferred to and from all Texas criminal justice entities.

I. DEMOGRAPHICS

NAME: _____ DOB: _____ AGE: _____ RACE: _____

WEIGHT: _____ HEIGHT: _____ SEX: ☐MALE ☐FEMALE

☐CCQ MATCH (CARE) CCQ NAME: _____ State ID #: _____

II. CURRENT/HISTORY OF HEALTH PROBLEMS, TO INCLUDE CHRONIC HEALTH PROBLEMS

MENTAL HEALTH AND INTELLECTUAL OR DEVELOPMENTAL DISABILITY (IDD)

☐NO CURRENT MENTAL HEALTH OR IDD NEEDS ☐NO HISTORY OF MENTAL HEALTH OR IDD NEEDS

☐MENTAL HEALTH DIAGNOSIS: _____ ☐IDD DIAGNOSIS: _____

☐ALZHEIMER'S DISEASE ☐DEMENTIA ☐COGNITIVE DISORDER(S) TYPE: _____

☐SUICIDAL ☐ACTIVE ☐RECENT ☐HISTORY ☐HAS BEEN PSYCHIATRICALLY STABLE FOR 30 OR MORE DAYS

COMPETENCY RESTORATION ☐INPATIENT ☐JAIL BASED ☐OUTPATIENT ☐UNKNOWN

DATE: _____ LOCATION: _____

MEDICAL (PHYSICAL HEALTH)

☐NO CURRENT MEDICAL PROBLEMS ☐NO HISTORY OF MEDICAL PROBLEMS

☐DIABETES ☐INSULIN ☐SPECIAL DIET

☐PREGNANCY NO. OF WEEKS: _____ ☐HIGH RISK

☐CARDIOVASCULAR/HEART TROUBLE DIAGNOSIS: _____

☐DRUG ABUSE ☐DETOX TYPE/STATUS: _____

☐ALCOHOL ABUSE ☐DETOX TYPE/STATUS: _____

☐ORTHOPEDIC PROBLEMS TYPE(S): _____

☐ASTHMA ☐DENTAL NEED ☐DIALYSIS ☐HYPERTENSION ☐OXYGEN ☐SEIZURE

☐RECENT SURGERY DATE(S): _____ TYPE(S): _____

III. SPECIAL NEEDS (CHECK ALL THAT APPLY)

HOUSING

☐NONE ☐SKILLED NURSING ☐EXTENDED CARE ☐PSYCHATRIC INPATIENT

☐ISOLATION DUE TO: _____ ☐OTHER: _____

TRANSPORTATION

☐ NO RESTRICTIONS ☐AMBULANCE ☐CRUTCHES/CANE/WALKER ☐WHEELCHAIR/WHEELCHAIR VAN

☐INDEPENDENT WITH SPECIALTY SHOES ☐PROSTHESIS TYPE(S): _____

OTHER NEEDS

☐ALLERGIES _____ ☐PENDING SPECIALTY CLINIC TYPE: _____

☐FUNCTIONAL LIMITATIONS: _____

IV. COMMUNICABLE DISEASES (CHECK ALL THAT APPLY)

☐HEPATITIS A ☐HEPATITIS B ☐HEPATITIS C

☐HIV/HIV ANTIBODY TEST DATE: _____ RESULTS: ☐NEGATIVE ☐POSITIVE CD4: _____ DATE: _____

☐SYPHILLIS DATE: _____ TYPE: _____ TREATMENT COMPLETED: ☐YES ☐NO

☐TUBERCULOSIS SKIN TEST GIVEN: ☐NO ☐YES RESULTS: ☐NEGATIVE ☐POSITIVE _____ MM*

X-RAY PERFORMED: ☐NO ☐YES RESULTS: ☐NORMAL ☐ABNORMAL DATE READ: _____

CLEARED FOR TRANSPORTATION ☐NO ☐YES

***NOTE: if any TB treatment has been recommended, the X-Ray was abnormal or skin test indicates infection please attach TB record**

V. OTHER HEALTH CARE PROBLEMS: _____

VI. CURRENT PRESCRIBED MEDICATIONS: ☐NONE

MEDICATION	DOSAGE	FREQUENCY	REASON

COMPLETED BY: _____ **TITLE:** _____

DATE: _____ **PHONE:** _____ **FACILITY:** _____

NOTE: For continuity of care and other healthcare concerns, please contact the receiving party in advance.
For TDCJ transfers, please call the Health Services Liaison at 936-437-3589
When screening substance abuse facility offenders, please contact the TDCJ Rehabilitation Programs Division Administrator at 936-437-2839 for offenders with any chronic disease/symptoms deemed unstable.

INSTRUCTIONS

This form MUST accompany all offenders transferred to and from all Texas criminal justice entities.

For the purposes of this form, the term "diagnosis" refers to a written diagnosis from a physician or licensed professional qualified to make a diagnosis.

I. Demographics:
   a. Print the inmate/patient's name, date of birth (DOB), age, race, weight and height.
   b. Place a check mark next to the appropriate label for sex.
   c. Select **CCQ Match** if there is a record of the inmate/patient in the cross-referenced MH/MR database (CARE); **CCQ Name**, print the inmate/patient's name from the CARE database if different from the booking/conviction name.
   d. Print the inmate/patient's State Identification (SID) number.

II. Current/History of Health Problems, including Chronic Health Problems *(Check all that apply)*
   a. Mental Health and Intellectual or Developmental Disability (IDD)
      i. Select **No Current Mental Health or IDD Needs**, if applicable.
      ii. Select **No History of Mental Health or IDD Needs**, if applicable.
      iii. Select **Mental Health**, if the inmate/patient currently has or has had a mental health diagnosis; print the diagnosis.
      iv. Select **IDD**, if the inmate/patient currently has or has had an intellectual or developmental disability; print the diagnosis.
      v. Select **Alzheimer's disease**, if applicable; print the diagnosis.
      vi. Select **Dementia**, if applicable; print the diagnosis.
      vii. Select **Cognitive Disorder(s)**, if applicable and indicate the type; print the diagnosis.
   b. Select **Suicidal**, if the inmate/patient has expressed suicidal thoughts or attempted suicide.
      1. Select **Active, Recent** or **History** to provide framework for receiving facility's knowledge about the inmate/patient.
      ii. Select **PSYCHIATRICALLY STABLE FOR 30 OR MORE DAYS**, if the inmate/patient has been stabilized in their mental health symptoms for more than 30-days. Example: Inmate/patient has not been on suicide watch/observation or committed to mental health inpatient care within the past 30-days.
      iii. Select **Inpatient, Jail Based, Outpatient** or **Unknown**; if the inmate/patient is or has participated in any of the listed applicable Competency Restoration programs. Print any known available dates and corresponding location of Competency Restoration occurrence.
   c. Medical (Physical Health)
      i. Select **No Current Medical Problems**, if applicable.
      ii. Select **No History of Medical Problems**, if applicable.
      iii. Select **Diabetes**, if the inmate/patient has a diagnosis.
         1. Select **Insulin**, if the inmate/patient requires insulin for management of diabetic symptoms.
         2. Select **Special Diet**, if the inmate/patient requires a special diet for management of diabetic symptoms (may be selected independently of selection of Insulin).
      iv. Select **Pregnancy**, if the inmate/patient is currently pregnant; and confirmed with a test; print the number of weeks of gestation; print unknown if number of weeks is not known.
         1. Select **High Risk**, if the pregnancy is considered high risk.
      v. Select **Cardiovascular/Heart Trouble**, if the inmate/patient has or has a history of coronary artery disease (CAD), heart attack, angina pectoris and/or congestive heart failure; print diagnosis.
      vi. Select **Drug Abuse**, if the inmate/patient is currently or has a history of substance abuse treatment.
         1. Select **Detox**, if the inmate/patient is currently or has recently been in detox; print current status of inmate/patient's detox, Example: Active Withdrawal Symptoms.

vii. Select **Alcohol Abuse**, if the inmate/patient is currently or has a history of alcohol abuse treatment.
    1. Select **Detox**, if the inmate/patient is currently or has recently been in detox; print current status of inmate/patient's detox, Example: Active Withdrawal Symptoms.
viii. Select **Orthopedic Problems**, if the inmate/patient has or has had chronic joint complaints or recent/current fractured or broken bones; print the types of complaints or locations of fracture or break.
ix. Select **Asthma**, if the inmate/patient has been diagnosed as a result of sudden attack shortness of breath accompanied by wheezing, caused by spasm of the airway or swelling of the airway.
x. Select **Dental Need**, if there are any current dental problems the inmate/patient claims need attention.
xi. Select **Dialysis**, if the inmate/patient is on dialysis and receiving treatment.
xii. Select **Hypertension**, if the inmate/patient is currently being treated with medications or diet.
xiii. Select **Oxygen**, if the inmate/patient requires current use of an oxygen tank continuously or as needed (supplemental) and/or uses a CPAP machine.
xiv. Select **Seizure**, if the inmate/patient has or has had current or history of seizures.
xv. Select **Recent Surgery**, if the inmate/patient has undergone a recent surgery; print the date or dates of the event and indicate the type of surgery or reason for surgery.

III. Special Needs *(Check all that apply)*

a. Housing
    i. Select **None**, if the inmate/patient does not currently require any specialized housing due to a physical or mental health concern, Example: the offender is eligible for general population with no special accommodations.
    ii. Select **Skilled Nursing**, if the inmate/patient has a temporary problem requiring inpatient nursing care.
    iii. Select **Extended Care**, if the inmate/patient has a permanent condition requiring long-term inpatient nursing care.
    iv. Select **Psychiatric Inpatient**, if the inmate/patient is in need of crisis management or is currently participating in inpatient-level psychiatric care.
    v. Select **Isolation due to**, if the inmate/patient is currently or needs to be in isolation due to a health problem. Example: active Tuberculosis, Chicken Pox or Measles; print the reason for the isolation.
    vi. Select **Other**, if the inmate/patient has a current need for specialized housing due to the medical and or mental health problem and print description of housing need/type.

b. Transportation
    i. Select **No Restrictions**, if the inmate/patient is able to independently walk greater than 25-yards and/or requires no assistance or assistive devices to move about.
    ii. Select **Ambulance**, if the inmate/patient requires an ambulance to transport between facilities.
    iii. Select **Crutches/Cane/Walker**, if the inmate/patient needs or utilizes crutches, a cane or a walker to move around.
    iv. Select **Wheelchair/Wheelchair Van**, if the inmate/patient requires or needs a wheelchair to move distances greater than 25-years and/or requires a wheelchair accessible van for transport between facilities.
    v. Select **Independent with Specialty Shoes**, if the inmate/patient is able to walk distances greater than 25-yards on their own if using specialty footwear.
    vi. Select **Prosthesis**, if the inmate/patient has a prosthesis; print a description.

c. Other Needs
    i. Select **Allergies**, if the inmate/patient has any known allergies; print description of all that apply
    ii. Select **Pending Specialty Clinic**, if the inmate/patient has a pending specialty clinic appointment or need; print a description of the type of specialty clinic and location, Example: Oncology chemotherapy at local hospital.
    iii. Select **Functional Limitations**, if the inmate/patient is unable, needs assistance or needs prompting to accomplish Activities of Daily Living (ADL); Example: can the inmate/patient eat, bathe, dress, toilet and/or move about independently? If not, to what degree is assistance needed; print description.

IV. Communicable Diseases
a. Select **Hepatitis A, Hepatitis B,** or **Hepatitis C**, if the inmate/patient has an active infection.
b. Select **HIV/HIV Antibody**, if the inmate/patient is suspected of having or has; print the test date and select the results (**Negative** or **Positive**) and print the last known CD4 count and Date, as applicable.
c. Select **Syphilis**, if the inmate/patient is suspected of having or has; print the date of diagnosis/testing and type; select treatment completion status (**Yes** or **No**).
d. Select **Tuberculosis**, if the inmate/patient is suspected of having or has a tuberculosis history.
    i. Select **No** or **Yes**, if a skin test was completed.
    ii. Select **Negative** or **Positive**, skin-test result outcomes; print the MM* or reaction, if no reaction print 0.
    iii. Select **No** or **Yes**, whether an X-Ray was performed.
    iv. Select **Negative** or **Positive**, X-Ray result outcomes; print the date of the reading.

V. Other Health Care Problems
a. Print any additional conditions the inmate/patient has that might indicate need of medical care, Example: body deformities, swelling, open wounds, skin discoloration, rashes, needle marks, severe dental problems, etc.

VI. Current Prescribed Medications
a. Select **None**, if the inmate/patient is not currently prescribed medications.
b. If the inmate/patient is prescribed medications complete areas of the table fully with, name of **Medication**, prescribed **Dosage**, prescribed administration **Frequency**, and **Reason** the inmate/patient is on the medication.

Upon completion of the form, fill out the following fields legibly: **Completed by**, **Title, Date**, **Phone**, and **Facility**