

HEALTH TRANSFER SUMMARY

CONFIDENTIAL – Purpose: For Continuity of Care

INSTRUCTIONS: Per §302.388 (2), Wis. Stats.: If the person initially completing this form is not a health care provider, within 24 hours of the transfer, a health care provider must review the form, sign in section #7, and forward to the receiving facility.

SENDING FACILITY	HEALTH OFFICE (If not located at sending facility)
Street Address: _____	Facility/Agency _____
City, State, Zip: _____	Phone # _____
Phone # _____ Fax # _____	Fax # _____

1. OFFENDER NAME _____	DOC# _____	DOB _____	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female
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TRANSFER DATE _____	RECEIVING FACILITY _____
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Copy of Medical Information Sent Booking Date (If less than 30 days): _____

2. PRECAUTIONS: BEHAVIORAL / MENTAL HEALTH INFORMATION AND OBSERVATIONS

NOTE: Check boxes describing behaviors observed at the time of transfer or within 2 weeks prior to the transfer. Explain as needed in "Other".

<input type="checkbox"/> Disoriented / Confused	<input type="checkbox"/> Self-Abusive Behaviors	<input type="checkbox"/> Suicide Attempts / Threats	<input type="checkbox"/> Hyper / Anxious
<input type="checkbox"/> Violent, Aggressive, Angry	<input type="checkbox"/> Sad, Crying, Withdrawn	<input type="checkbox"/> Unusual / Bizarre Behavior	<input type="checkbox"/> None Observed
<input type="checkbox"/> Suicide Watch (within past 12 months), if known. If checked, give date(s) _____			
<input type="checkbox"/> Other (Attach additional sheets or call phone number above) _____			

Suspect Drug / Alcohol Use Within Past 7 Days? Yes No If Tested, Date And Results: _____

Withdrawal History Yes No - If Yes, Withdrawal Symptoms Within Past Two Weeks? Yes No

3. MEDICAL CONDITIONS:

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Prescribed Diet	<input type="checkbox"/> None Known
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Asthma	<input type="checkbox"/> Seizure Activity	

Currently Pregnant, Expected Delivery Date _____

Pregnancy Within Past Six Weeks – If checked, list any health complications _____

Allergies (List) _____ **No Known Allergies**

Hospitalizations / ER Visits / Surgeries (Within last 6 months) Date/Reason _____

Special Needs – If checked, list _____

Future Health Care Appointments (Dates, Physician/Clinic, Phone #) _____

Other: _____

4. TUBERCULOSIS HISTORY Unknown

Date Last PPD Test	Result (mm)	Date Last Chest X-Ray	Result
Last Quantiferon TB Gold	Results	Check Box If INH Preventive Treatment Completed <input type="checkbox"/> Date Completed: _____	Check Box If Treatment Completed For Active TB <input type="checkbox"/> Date Completed: _____

5. CURRENT MEDICATIONS AT SENDING FACILITY

Copy of Medication Sheet Attached Medications Sent **No Prescribed Medications**

Medication Name, Dose, Frequency	Medication Name, Dose, Frequency

6. PRINT NAME AND TITLE OF PERSON COMPLETING FORM _____	SIGNATURE _____	DATE _____
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7. HEALTH CARE PROVIDER REVIEW (Required within 24 hours of transfer if person completing form is not a health care provider)

PRINT NAME AND TITLE OF HEALTHCARE PROVIDER _____	SIGNATURE OF HEALTHCARE PROVIDER _____	DATE _____
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Offender Seen by Health Care Provider During Current Incarceration Yes No

Form Reviewed: Accurate as Initially Completed Revisions Made Supplemental Documents Provided

8. HEALTH TRANSFER SUMMARY ACKNOWLEDGMENT (To be Completed by Receiving Facility)

Receiving Facility: _____ HAS RECEIVED HTS INFORMATION REGARDING ABOVE OFFENDER

DATE / TIME _____	PRINT NAME OF PERSON RECEIVING HEALTH TRANSFER INFORMATION _____
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HEALTH TRANSFER SUMMARY INSTRUCTIONS

Sec. 302.388, Wis. Stats., requires jails, houses of corrections and prisons to provide health care information when an inmate transfers from one facility to another. The sending facility shall provide either a fully completed Health Transfer Summary (HTS) or the complete medical record and a partially completed at HTS *at the time of transfer*. The HTS and medical records are protected by confidentiality laws.

PLEASE PRINT LEGIBLY IN ALL FIELDS

1. Inmate Information:

- Only DOC inmates have an assigned DOC#.
- When a sending facility is forwarding an inmate's medical record to the receiving facility, check the box labeled "Copy of Medical File Sent" and attach an HTS with Sections 1 and 6 completed, **except** that DOC completes an alternative form for inmates transferred from a DOC facility to a county jail contract bed.
- Complete the entire HTS when the medical record is not being sent.
- Note that DOC and other multi-facility jurisdictions do not need to complete an HTS when transferring an inmate within their system.

2. Precautions: Behavioral/Mental Health Information and Observations

- Check boxes to indicate observed behaviors at the time of transfer or within 2 weeks prior to transfer.
- Check "Suicide Watch" box if the inmate was on suicide watch at time of transfer or within 12 months prior to transfer, if known by person completing the HTS.
- Check "None Observed" box for an inmate without precautions, concerns or observations.

3. Medical Conditions

- Check boxes to indicate known medical conditions.
- Include information on recent traumas/injuries, special diets, or problems/complications.
- "Other" may include a known disability, or prosthetic devices such as canes/walkers, eyeglasses/contacts, dentures, wheelchairs and any other special equipment.
- Check "None Known" for an inmate with no known medical conditions.

4. Tuberculosis History

- Check "Unknown" box if person completing HTS does not know the TB information.
- Enter date of most recent PPD test and the result in mm when known.
- Enter date of most recent Chest X-ray and result when known.
- Enter date of most recent Quantiferon TB Gold test and result when known.
- Check box and enter date of completion of preventive (INH) treatment or treatment for active TB when applicable.

5. Current Medications

- Attach a list of medications inmate is receiving at the time of transfer including name of medication, and dose/frequency or enter the information on the HTS. Attaching a list is preferred.
- Check the "Medications Sent" box when medications are being sent with the inmate.
- Check the "No Medications" box when the inmate was not taking medications at the time of transfer.

6. Person Completing Health Transfer Summary

- Complete this section for all transfers.
- Print name and title of person completing the HTS.
- Sign and date.

7. Health Care Staff Review: Required if person completing the HTS is not a health care professional.

- Complete review within **24 hours** of receipt of the inmate.
- Print name/title, date of review, and sign.
- Check "YES" or "NO" to indicate whether a health professional saw the inmate during the stay at sending facility.
- Check the appropriate box to indicate whether the original HTS was accurate.

8. Health Transfer Summary Acknowledgment: To be completed at receiving facility by jailer or health care staff.

- Complete this section immediately upon receipt of inmate including the date and time.
- File the HTS in the inmate medical file.