INMATE MEDICATION INFORMATION FORM

INMATE INFORMATION

FULL LEGAL NAME OF INMATE: _____

STREET ADDRESS: _____CITY: _____ STATE: _____ ZIP CODE: _____

DOB: _____ BOOKING #:_____

JAIL LOCATION: TOWER: _____ FLOOR: _____ POD#:_____

FAMILY CONTACT INFORMATION

FAMILY CONTACT NAME: _____ RELATIONSHIP _____

STREET ADDRESS: _____CITY: _____ STATE: _____ ZIP CODE: _____

DAYTIME PHONE: _____ EVENING PHONE: _____

CONTACT SIGNATURE: x_____

PSYCHIATRIST/TREATMENT FACILITY INFORMATION

PSYCHIATRIST/LAST TREATMENT FACILITY: _____ DATE LAST TREATED: _____

STREET ADDRESS: _____CITY: _____ STATE: _____ ZIP CODE: _____

PHONE: _____ FAX: _____

MEDICAL INFORMATION

DIAGNOSIS: _____

DAYTIME MEDICATIONS: _____

_____

NIGHTTIME MEDICATIONS: _____

_____

PRIOR ADVERSE MEDICATION EFFECTS (i.e. side effects, allergies, poor efficacy): _____

_____

_____

IS SUICIDE A CONCERN? NO _____YES _____ IF YES, WHY? _____

_____

_____

_____

OTHER MEDICAL CONCERNS: _____

_____

_____

_____

MEDICAL DOCTOR'S NAME: _____ OFFICE PHONE: _____

STREET ADDRESS: _____CITY: _____ STATE: _____ ZIP CODE: _____

JAIL MENTAL HEALTH SERVICE FAX NUMBERS

MEN'S FAX: 213-972-4002 WOMEN'S FAX: 323-568-4650

SHERIFF'S MEDICAL SERVICES BUREAU FAX NUMBER

213-217-4850

FAX TO BOTH NUMBERS WHEN OTHER MEDICAL CONDITIONS APPLY