STANISLAUS COUNTY INMATE MEDICATION INFORMATION FORM

Full Legal Name_____ Date of Birth_____

AKA's/Nickname_____ SS#_____

Street Address_____ City/State/Zip_____

If Homeless, County Last Resided in?_____

Booking #_____ Jail Location_____

FAMILY CONTACT INFORMATION

Family Contact Name_____ Relationship_____

Street Address_____ City/State/Zip_____

Daytime Phone #_____ Evening Phone #_____ Fax #_____

Contact Signature_____

PSYCHIATRIST / TREATMENT FACILITY INFORMATION

Psychiatrist / Last Treatment Facility_____ Date Last Treated_____

Street Address_____ City/State/Zip_____

Daytime Phone #_____ Fax #_____

MENTAL HEALTH AND MEDICAL INFORMATION

Diagnosis_____

List Medications, Dose & Frequency_____

_____

Prior Adverse Medication Effects (i.e. side effects, allergies, poor efficacy)_____

Are you concerned that inmate may harm himself?_____Yes_____No

Why?_____

_____

Previous Attempts/Method_____

_____

Other Medical Concerns

_____

Medical Doctor's Name_____ Office Phone #_____

Other Medications:_____

Additional Information:_____

_____

_____

FAX FORM TO STANISLAUS COUNTY PSYCHIATRIC SERVICES: Fax# 209-525-5623 Monday-Friday; 209-525-5673 Weekends, (Message Phone: 209-525-5622)