INMATE MEDICATION INFORMATION FORM

Date:_____
Booking Number:_____

INMATE INFORMATION

FULL LEGAL NAME OF INMATE: _____ DOB: _____

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

FAMILY CONTACT INFORMATION

FAMILY CONTACT NAME: _____ RELATIONSHIP _____

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

DAYTIME PHONE: _____ EVENING PHONE: _____

PSYCHIATRIST/TREATMENT FACILITY INFORMATION

PSYCHIATRIST (Current or Last Seen)_____ DATE LAST TREATED: _____

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

PHONE: _____ FAX: _____

MEDICAL INFORMATION

DIAGNOSIS: _____

DAYTIME MEDICATIONS: _____

_____

NIGHTTIME MEDICATIONS: _____

_____

PAST PROBLEM MEDICATION EFFECTS (i.e. side effects, allergies, medication that did not work): _____

_____

HOW LONG HAS IT BEEN SINCE MEDICATIONS WERE TAKEN?_____

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

DOWNTOWN JAIL (RECEIVING FACILITY) FAX: 661-868-5312
LERDO FACILITY FAX: 661-391-7997 OR 661-391-7978
SHERIFF'S MEDICAL SERVICES BUREAU FAX– 661-391-7386

***FAX TO Mental Health AND SHERIFF'S MEDICAL WHEN OTHER MEDICAL CONDITIONS APPLY**