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ADMINISTRATIVE POLICIES AND PROCEDURES State of Tennessee Department of Correction	Index #: 113.20	Page 1 of 16
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Approved by: Tony Parker		
Subject: INITIAL HEALTH SCREENING AND PHYSICAL EXAMINATIONS		

I. AUTHORITY: TCA 4-3-603, TCA 4-3-606, and TCA 41-21-107a.

II. PURPOSE: To ensure that each inmate receives an initial comprehensive clinical screening and intake physical during the intake and diagnostic process and upon intersystem transfers as well as, periodic health appraisals thereafter, with a goal of preventing the exacerbation of an existing condition.

III. APPLICATION: Wardens/Superintendents, Health and Behavioral Health Administrators, Therapeutic Program Directors, health care staff at all institutions, all inmates, medical contractors, and privately managed institutions.

IV. DEFINITIONS:

A. Advanced Directive: An individual instruction or written statement relating to the subsequent provision of health care for the individual in which the inmate or his/her healthcare agent expresses his/her choice(s) regarding healthcare services to apply in the event he/she is no longer capable of expressing a choice. Advance directives may include but not be limited to, a living will, an advance care plan, or durable power of attorney for health care.

B. Comprehensive Clinical Health Record Review: A periodic review of Clinical Health records (physical and behavioral health) to ensure that inmate's clinical files are complete and fully documented.

C. Medical Practitioner: A licensed physician or mid-level provider.

D. Periodic Health Appraisal: Physical health examination in which inmates clinical status is ~~are~~ evaluated for risk factors and disease, with the goal of preventing the onset of disease or worsening of a~~n~~ preexisting condition.

E. Qualified Health Professional: Clinical staff who are legally authorized by licensure, registration, or certification to perform direct or supportive health care services and whose primary responsibility is to provide clinical services to inmates in the custody of the Tennessee Department of Correction (TDOC). Examples of qualified health professionals may include physicians, dentists, physician assistants, nurse practitioners, nurses, psychiatrists, senior psychological examiners, psychologists, clinical social workers, etc.

F. Safekeeping: Defendants who have been court-ordered to TDOC physical custody and who have not been adjudicated and/or formally sentenced.

G. Strategic Technology Solutions (STS): A division of the Tennessee Department of Finance and Administration responsible for managing and operating the Information Technology (IT) and support functions of the Tennessee Department of Correction.

V. POLICY: All inmates (to include safekeeping) entering the TDOC shall be provided with an initial comprehensive clinical screening and periodic physical examinations as indicated in accordance with the schedule outlined in this policy.

VI. PROCEDURES:

A. Initial Health Screening and Questionnaire

1. The health administrator for each institution shall ensure:

a. That a LPN, RN, or mid-level provider performs an initial health screening on each inmate immediately upon arrival at the institution.

b. The health screening shall consist of a completed Health Questionnaire, CR-2178.

c. Review of the CR-2178, in accordance with institutional procedures shall generate referrals to appropriate medical and behavioral health personnel.

d. A copy of the TDOC and/or institutional *Inmate Rules and Regulations Handbook* shall be provided to the inmate.

e. Process is completed prior to the inmate being placed into general population.

2. Nursing staff shall complete the Health Questionnaire, CR-2178.

3. Transient inmates do not need to be issued an institutional inmate handbook but do need to sign the CR-2178 indicating that an explanation of how to access health care at the receiving facility was given in accordance with Policy #113.22.

B. Health Examinations

1. Intake Physical Examination: The intake health examination shall be completed within 14 calendar days of the inmate's arrival at the reception/classification/diagnostic center and shall consist of the following procedures:

a. An outpatient health record shall be originated by completing a Health History, CR-2007, and Report of Physical Examination, CR-3885.

b. Physiological measurements shall be completed by health care providers and shall include height, weight, temperature, pulse, blood pressure (sitting), and visual acuity screening (Snellen) of both eyes. All of the results shall be fully recorded on Page 1 of CR-2007.

c. The following screening tests shall be performed:

(1) All Inmates:

(a) Complete Blood Count w/differential (CBC)

(b) Automated Blood Chemistry Profile (including lipid profile)

(c) Serology for Syphilis

(d) Screening for Gonorrhea and Chlamydia using an appropriate laboratory test

(e) Urinalysis; document results on the Urinalysis Dipstick Results, CR-4186

(f) Hearing screening followed by a reflex audiometric test if indicated, noting binaural hearing loss

(g) Initial tuberculosis screening according to Policy #113.44

(h) Hepatitis screening test (Use the Hepatitis C antibody for viral Hepatitis C and use the Hepatitis B surface antigen for Hepatitis B) unless the inmate choses to opt-out/refuse hepatitis testing

(i) HIV Testing according to Policy #113.45. (NOTE: Tennessee statute requires testing of all inmates under the age of 21 years, unless the inmate has previously been tested pursuant to TCA 39-13-521, mandatory HIV testing, and the results are available and verifiable).

(j) DNA testing (according to Policy #113.92 and TCA 40-35-321).

(k) Age 50 and Older: Fecal Occult Blood Test (FOBT)

(l) Additionally for all female inmates:

(1) Pelvic Examination with PAP smear

(2) Breast examination and education on breast self-exam.

(m) Female Inmates Age 40 and Older:

(1) Mammogram

(2) Chest X-ray, if indicated

(3) Electrocardiogram, if indicated

(n) Male Inmates Age 45 and Older:

(1) Chest x-ray, if indicated

(2) Electrocardiogram, if indicated

(o) The following guidelines should be used in assessing prostatic health.

(1) Male Inmates Age 40: Begin discussions with African American males, and inmates with positive family history with a first degree relative or BRCA1 in BRACA2 mutations.

(2) Male Inmates Age 50: Begin discussion regarding testing risk versus benefits unless there is less than a 10 year life expectancy or 75 years of age.

(3) Male Inmates Over Age 75: No Screening.

(4) When risk factors indicate a PSA test is needed and the PSA test values are greater than 4.0 ng/ml, repeat PSA in six weeks. Before repeating PSA, eliminate possible factors contributing to elevation i.e. recent ejaculation, trauma, or prostatitis. The inmate should be counseled appropriately to avoid erroneous elevations. If the PSA remains elevated, refer to urologist for evaluation to determine necessity for biopsy. Repeat PSA every two years with digital rectal examination

d. A diphtheria tetanus booster, and other immunizations as recommended by the Tennessee Department of Health, shall be administered to inmates in accordance with Policy #113.43. The MMR (measles, mumps, and rubella) vaccination should be administered at intake to women of child-bearing age (16-45) who have reported never having received the vaccine as an adult.

e. Following a review of the health history, the physician or mid-level provider shall perform a complete physical examination of each inmate. The clinical evaluation shall include all items as defined on Report of Physical Examination, CR-3885. A clear description of findings should be documented on the CR-3885 in all categories. All examination findings shall be fully and legibly documented on the physical examination report, including normality, abnormality, and summary of physical defects, diagnoses, and health classification. Each item should be evaluated separately by checking normal, abnormal, or documentation of refusal, on Refusal of Medical Services, CR-1984, as appropriate. The date of examination, full signature, and the professional title (printed and signed) of the physician or mid-level provider conducting the physical examination is required.

f. At the time of the physical examination, the physician or mid-level provider shall determine the appropriate health classification of the inmate. (See Policy #113.21 for detailed procedures and forms usage)

g. The offender management screen (OMS) screen LHSE (Health Assessment) shall be used to document the health classification. Limitations shall be documented on Option 3, "Comments".

h. Additional diagnostic procedures may be requested at this time, based on the inmate's identified health-related risk factors, or other health or behavioral health problems.

i. All diagnosed major clinical problems identified during the intake physical shall be recorded by a health services provider on the Major Problem List, CR-1894.

j. Inmates with significant health care problems as identified by the physician or mid-level provider conducting the health history review and physical examination shall have a treatment plan developed and implemented within 14 days after the inmate's arrival at the reception/classification/diagnostic center. (See Policy #113.32) These inmates are generally expected to be those given a health classification of Class B or Class C. (See Policy #113.21)

k. When an inmate is moved prior to the completion of their health screening, the Health Services Administrator shall notify the receiving Health Services Administrator that the inmate enroute does not have a complete health screening and document in the comments on Health Records/Medication Movement Document, CR-2176, and Transfer/Discharge Health Summary, CR-1895, that the inmate's health screening is incomplete.

l. Returning Inmates: If an inmate returns to TDOC custody within 90 days of release, the health care staff is not required to perform a complete intake physical examination. At a minimum, syphilis, GC/chlamydia, and TB testing shall be performed, and a brief, self-reported history shall be taken from the inmate to determine if any significant health problems have developed during the period of release into the community.

2. Periodic Health Appraisal: A PHA shall be performed for all inmates according to the following age groups:

Age Group	Frequency
49 and under	Every three years
50-64	Every two years
65 and over	Every year

a. The PHA shall be performed during the inmate's birth month by either a mid-level provider or physician at approximately the same time of the inmate's annual TB screening, unless a PHA (initial or periodic) was performed within the past six months. The PHA shall then be performed on the next birth month the inmate is due for a PHA.

(1) Each month, a birth month list for all assigned inmates with a birthday one month out, is obtained from Strategic Technology Solutions (STS) and distributed to health administrators via the Central Office Health Services. This report may be used to assist each facility in identifying inmate's requiring a PHA.

(2) The Transfer/Discharge Health Summary, CR-1895, shall be reviewed for all incoming inmates to determine if the PHA is current. Inmates requiring a PHA shall be scheduled along with the next group to receive physicals

(3) The annual screening/review listing shall be maintained on file in the clinic/infirmary and the date of the PHA shall be entered or checked "NI" (not indicated).

b. At a minimum, the following procedures shall be conducted during the PHA for all inmates:

(1) Review the health record to identify current health problems and risks to health.

(2) Record the vital signs, including weight, pulse, temperature, and blood pressure. The results shall be documented on Report of Physical Examination, CR-3885.

(3) Complete laboratory tests including:

(a) Chemistry profile (including lipid profile)

(b) Complete blood count (CBC) with differential

(c) Complete urinalysis; document results on the Urinalysis Dipstick Results, CR-4186

(d) Fecal Occult Blood Test (FOBT) over age 50

(e) Opt out HCV testing, unless previously obtained

(f) Other tests as ordered by the prescribing clinician

(4) Additional procedures for females:

(a) Annual PAP smear and pelvic examination

(b) Counseling and education on breast self-examination

(c) Annual breast examination followed by a mammogram, if indicated by breast examination

(d) Mammograms may be conducted either during the birth month or the month prior to the birth month, and:

(1) Females 40-49 years old - every two years

(2) Females 50 years and older - every year

(5) Additional procedures for males:

(a) Digital rectal examination

(b) Counseling and education on testicular self-examination

(c) Prostatic health assessment as outlined in VI.(B)(1)(o) of this policy

c. The documentation of the periodic health appraisal shall include all items as defined on Report of Physical Examination, CR-3885. A clear description of findings should be documented on the CR-3885 in all categories. Each item should be evaluated separately by checking normal, abnormal, or documentation of refusal, on Refusal of Medical Services, CR-1984, as appropriate. The date of examination, full signature, and the professional title (printed and signed) of the physician or mid-level provider conducting the physical examination is required.

d. During every PHA, each inmate shall be counseled regarding Advanced Directives. A new Advanced Care Plan, PH-4194, or a review of this form for update, shall be completed, expressing the inmate's informed decisions regarding options for end-of-life services, to ensure their wishes are honored. The qualified health Professional shall document completion, or update, of the PH-4194 on the Report of Physical Examination, CR-3885, and file this form in the inmate's health record in accordance with Policy #113.50.

e. Special health needs: At the time of the health appraisal, inmates requiring close medical supervision shall be identified. A written, individual treatment plan, which includes directions to health care staff and other personnel regarding their roles in the care and plan represents one aspect of the special health program for inmates requiring close medical supervision. (See Policy #113.32 Levels of Care)

f. Comprehensive Clinical Health Record Review: The Health Service Administrator/designee and the Behavior Health Administrator/designee shall conduct a comprehensive clinical health record review upon receipt of an inmate transferred from another institution and at the end of an inmate's birth month. This review shall be documented on the Comprehensive Clinical Record Review, CR-4201, with the health administrator/behavioral health administrator's signature, time, date. This review will ensure completion of the PHA and supporting documentation. In the event a comprehensive clinical health record review was already conducted during Chronic Care Clinic, in accordance with Policy #113.32, the health/behavioral health administrator may consider the review completed.

VII. ACA STANDARDS: 4-4285, 4-4347, 4-4350**,** 4-4356, 4-4357, 4-4362, 4-4363, 4-4364, 4-4365, 4-4366, 4-4367, 4-4370, 4-4371, 4-4372, 4-4399, and 4-ACRS-4C-07.

VIII. EXPIRATION DATE: March 15, 2023.

TENNESSEE DEPARTMENT OF CORRECTION
HEALTH QUESTIONNAIRE

INMATE NAME: _____ TDOC ID _____ DOB _____

RECEIVING INSTITUTION: _____ DATE: ___/___/_____ TIME: _____ a.m./p.m.

INITIAL INTAKE: _____ TEMPORARY TRANSFER: _____ PERMANENT TRANSFER: _____

INQUIRE:

1. Do you have any barriers to learning? ☐ Vision ☐ Hearing ☐ Reading ☐ Writing ☐ None
2. Do you speak/read English? Speak: ☐ Yes ☐ No Read: ☐ Yes ☐ No
3.. Have you ever had a positive TB test? ☐ Yes ☐ No If **yes**, describe _____
4. Are you being treated for any illness or health problem (*including dental, venereal disease, or other infectious diseases*)?
   ☐ Yes ☐ No If **yes**, describe: _____
5. Do you have any physical, mental or dental complaints at this time? ☐ Yes ☐ No
   If **yes**, describe: _____
6. Are you currently taking any medication(s)? ☐ Yes ☐ No
   If **yes**, was the medication transferred with the inmate? ☐ Yes ☐ No
   If **yes**, describe (what used, how much, how often, date of last use, and any problems)
7. Have you recently or in the past, abused alcohol or other drugs, including prescription drugs? ☐ Yes ☐ No
   If yes, What? _____ How much? _____
8. Have you ever been hospitalized for using alcohol or other drugs, including prescription drugs? ☐ Yes ☐ No
   If **yes**, when? _____
9. Do you have any allergies? ☐ Yes ☐ No If **yes**, describe: _____

(For women)

10. a) LMP _____ b) Are you pregnant? ☐ Yes ☐ No Number of months _____
    c) Have you recently delivered? ☐ Yes ☐ No Date: _____
    d) Are you on birth control pills? ☐ Yes ☐ No
    e) Any gynecological problems? ☐ Yes ☐ No
11. Screening for MRSA Infections:
    a) Do you have any lesions, sores or insect bites? ☐ Yes ☐ No
    If **so**, do you have any open/draining lesions, sores, or insect bites? ☐ Yes ☐ No
    If **yes**, where are these lesions? _____

OBSERVE:

1. Behavior (including state of awareness, mental status, appearance, conduct, tremor and sweating):
   ☐ Normal ☐ Abnormal If **abnormal**, describe: _____
2. Skin Assessment (*including needle marks, trauma markings, bruises, lesions, jaundice, rashes, tattoos, and infestation(s)*
   ☐Yes ☐ No
   If **yes**, describe: _____
3. Is there evidence of Abuse or Trauma? ☐ Yes ☐ No If yes, describe: _____

TENNESSEE DEPARTMENT OF CORRECTION
HEALTH QUESTIONNAIRE

MENTAL HEALTH:

1. Is the inmate presenting behavior(s) that are considered: ☐ Anxious ☐ Antagonistic/Hostile ☐ Hallucinations ☐ Withdrawn/Avoidant ☐ Depressed/Hopeless ☐ No
2. Is the inmate presenting disorganized thought? (*Unable to track questions and/or present responses in logical or connected manner*) ☐ Yes ☐ No
3. Have you ever been in a mental hospital? ☐ Yes ☐ No
   If **yes**, when? _____ How often? _____
4. Have you ever been treated for mental health? ☐ Yes ☐ No
   Have you ever been treated for substance use? ☐ Yes ☐ No
5. Have you ever attempted to kill yourself? ☐ Yes ☐ No If **yes**, when? _____
   How? _____ How many times? _____
6. Are you thinking about suicide now? ☐ Yes ☐ No
   If yes, do you have a plan? ☐ Yes ☐ No
7. Has a parent, other family member, or close friend committed suicide? ☐ Yes ☐ No If **yes**, who? _____
8.. Do you have a history of past or current head trauma? ☐ Yes ☐ No If **yes**, explain type of injury: _____
   _____
9.. As an adult or child, have you personally experienced being: ☐ Sexually abused ☐ Physically abused ☐ Emotionally abused
   ☐Yes ☐ No ☐Yes ☐ No ☐Yes ☐ No
   When? (year) and by whom? _____

DISPOSITION:

_____ Intake housing _____ Intake housing with prompt referral appointment *(health, mental health, substance use treatment)*

_____ General housing _____ General housing with prompt/referral appointment

Referred to appropriate health, mental health or substance use provider ☐ Yes ☐ No

Contacted appropriate health, mental health, or substance use provider due to emergency ☐ Yes ☐ No

Additional comments on Progress Notes (CR-1884): ☐ Yes ☐ No

I have received information regarding the procedure for obtaining routine and emergency health care (*medical, dental, substance use, and/or mental health, and co-pay requirements*). These have been explained to me and I understand how to access healthcare services in the form of:

☐ **Orientation Handbook (i.e. Inmate Handbook)**
☐ **Transient inmate information-describing how to access healthcare**

_____
Inmate Signature

_____
Employee Name Printed

_____
Employee Signature and Title

TENNESSEE DEPARTMENT OF CORRECTION

HEALTH HISTORY

Inmate Name: _____

TDOC ID _____

_____
INSTITUTION

SS# _____ **Gender** _____ **Age** _____ **D.O.B.** _____

Next of Kin: Name: _____ Relation: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: **Area Code** _____ **Number** _____

Date Completed: _____ Month _____ Day _____ Year

Height: _____ Weight: _____ Hair Color: _____ Color of Eyes: _____

Blood Pressure (Sitting): _____ Temp: _____ Pulse _____ Resp. _____

DATE, if done on Admission			
Serology		EKG	
Urinalysis		Chest X-Ray	
CBC		Hemoccult	
Chem. Scan			
Td Booster			
Other			

ALLERGIES: _____

Date or TB Skin Test _____

Date Read _____ Results _____ (Record in MM.)

Visual Acuity (Snellen) **R.** _____ **L.** _____

CURRENT MEDICATIONS: (Specify drug, strength, dosage form and frequency)

TENNESSEE DEPARTMENT OF CORRECTION

HEALTH HISTORY

Inmate Name: _____

TDOC ID _____

1. Family History: Have any of your family or relatives had any of the following? If so, specify who:

Heart Disease	_____	Tuberculosis	_____	Cancer	_____
Sickle Cell	_____	Diabetes	_____	Seizures	_____
Hypertension	_____	Mental Illness	_____	Other	_____

Substance Use _____ Are your parents still alive? _____

2. Social History:

Highest Grade Completed _____ Usual Occupation _____ Marital Status _____

Previous Incarcerations _____ Old Number (TN, Other State, Federal) _____

Prior to Incarceration: _____

Used alcohol: Yes _____ No _____ If yes, Daily _____ Weekly _____ Rarely _____

Other habit forming drug(s) Yes _____ No _____ Daily _____ Social _____

Name(s) of Drug(s) _____

Ever injected drugs (even once)? Yes _____ No _____

3. When did you last see a doctor? _____

For What Reason: _____

4. Have you ever been told by a doctor that you now have or have had any of the following:
Answer questions by checking **yes** or **no**

YES		NO	COMMENT(S)
☐ a.	Rheumatic Fever	☐	
☐ b.	Heart trouble	☐	
☐ c.	High Blood Pressure	☐	
☐ d.	Thyroid trouble or Goiter	☐	
☐ e.	Diabetes	☐	
☐ f.	Kidney infections or Stones	☐	
☐ g.	Jaundice, hepatitis or liver disease	☐	
☐ h.	Ulcer	☐	
☐ i.	Pneumonia	☐	
☐ j.	Tuberculosis	☐	
☐ k.	Gallbladder Disease	☐	
☐ l.	Sexually Transmitted Infection/Disease (Venereal Disease)	☐	
☐ m.	Asthma	☐	
☐ n.	Emphysema	☐	
☐ o.	Anemia	☐	
☐ p.	Hemophilia	☐	
☐ q.	Cancer	☐	
☐ r.	Epilepsy or Seizure disorder	☐	
	Last seizure _____ Medication		
☐ s.	Allergies, (if yes, what? _____)	☐	
☐ t.	Any other serious illness, or injuries, operations or hospitalizations?	☐	
☐ u.	Any history of treatment in a Mental Health Clinic or Psychiatric Hospital?	☐	

☐ v. Any history of Substance Use Treatment either in or out patient? ☐ _____

Hospitalizations

DATE	NAME OF HOSPITAL	LOCATION	REASON

Surgical History

DATE	TYPE OF SURGERY	HOSPITAL/SURGICAL CTR	SURGEON

NO		YES	COMMENT(S)
5.			
☐ a.	Has there been any change in your weight in the past year? 1. Lost ☐ How much? _____ 2. Gain ☐ How much? _____	☐	_____
☐ b.	Have you ever had excessive anxiety/nervousness, depression or worrying?	☐	_____
☐ c.	Have you noticed a change in size or color of any wart or mole, or the appearance of a new one?	☐	
☐ d.	Any itching, skin rash or boils?	☐	_____
☐ e.	Do you use tobacco?	☐	
☐	1. Chew	☐	_____
☐	2. Pipe	☐	
☐	3. Cigars	☐	_____
☐	4. Cigarettes	☐	
	5. How many cigars, cigarettes, or pipes do you smoke in 24 hours? _____		_____
6.	**HEAD AND NECK**		
☐ a.	Do you have dizzy spells?	☐	_____
☐ b.	Do you have frequent headaches?	☐	
	How often? _____ What medicine helps your headaches? _____		_____
☐ c.	Do you have any lumps or swelling in your neck, armpits, groin or other areas?	☐	_____

TENNESSEE DEPARTMENT OF CORRECTION

HEALTH HISTORY

Inmate Name: _____

TDOC ID _____

NO		YES	COMMENT(S)
7.	**EYES**		
☐ a.	Do you wear glasses or contact lens?	☐	
.	For how long? _____		
☐ b.	Do you see double?	☐	
☐ c.	Do you ever see colored halos around lights?	☐	
☐ d.	When your eyes were last examined?	☐	
☐ e.	Do you have trouble seeing objects at a distance or near objects such as a newspaper?	☐	
☐ f.	Do you have vision in both eyes?	☐	
8.	**EARS**		
☐ a.	Do you have difficulty hearing?	☐	
☐ b.	Have you had any earaches lately?	☐	
☐ c.	Do you have repeated buzzing or ringing in your ears?	☐	
☐ d	Do you have a hearing aid(s)?	☐	
9.	**MOUTH, NOSE AND THROAT**		
☐ a.	Do you have any trouble with your teeth or gums?	☐	
☐ b.	When did you last see a dentist?	☐	
☐ c.	Have you ever had sinus problems?	☐	
☐ d.	Does your nose ever bleed for no reason at all?	☐	
☐ e.	Is your voice more hoarse now than in the past?	☐	
10.	**RESPIRATORY**		
☐ a.	Do you have a chronic cough?	☐	
☐ b.	Do you cough up any material?	☐	
☐ c.	Ever have trouble getting your breath after climbing one flight of stairs or walking one city block?	☐	
☐ d.	Do you have frequent colds or influenza attacks?	☐	
☐ e	Do you have sleep apnea?	☐	
☐ f.	Do you use a CPAP/BiPAP Machine?	☐	
11.	**CARDIOVASCULAR**		
☐ a.	Ever get pains or tightness in your chest?	☐	
☐ b.	Ever been bothered by a racing heart?	☐	
☐ c.	Do you have shortness of breath while doing your usual work?	☐	
☐ d.	Need more pillows at night to breathe?	☐	
☐ e.	Do you have swollen feet and ankles?	☐	
☐ f.	Do you use a lot of salt on your food?	☐	
☐ g.	Do you have a pacemaker?	☐	
☐ h.	Do you have a defibrillator?	☐	

TENNESSEE DEPARTMENT OF CORRECTION

HEALTH HISTORY

Inmate Name: _____

TDOC ID _____

NO		YES	COMMENT(S)
12.	**DIGESTIVE**		
☐ a.	Do you suffer discomfort in the pit of your stomach?	☐	
☐	1. Nausea	☐	
☐	2. Vomiting	☐	
☐	3. Indigestion	☐	
☐	4. Heartburn	☐	
☐ b.	Is it painful or difficult for you to swallow liquids or solid foods?	☐	
☐ c.	Do you have trouble with bowel movements?	☐	
☐	1. Hemorrhoids	☐	
☐	2. Bleeding	☐	
☐	3. Constipation	☐	
☐	4. Diarrhea	☐	
☐	5. Bloody or Black Stools	☐	
☐	6. Rectal Pain	☐	
13.	**URINARY**		
☐ a.	Frequently get up at night to urinate?	☐	
☐ b.	Ever had burning or pains when urinating?	☐	
14.	**MUSCULOSKELETAL**		
☐ a.	Have stiff or painful muscles or joints?	☐	
☐ b.	Are your joints ever swollen?	☐	
☐ c.	Have you ever had any broken bones?	☐	
☐ d.	Have difficulty bending or moving?	☐	
15.	***SKIN***		
☐	Tattoos, piercings, lesions, ulcers, tags, moles, insect bites, rashes, or infections?	☐	
16.	***FOR MALES ONLY***		
☐ a.	Is your urine stream very weak and slow?	☐	
☐ b.	Has a doctor ever told you that you have prostate trouble?	☐	
☐ c.	Ever had discharge from your penis?	☐	
☐ d.	Do you have any pain, swelling, sores or lumps on your testicles or penis?	☐	
17.	***FOR FEMALES ONLY***		
☐ a.	Have you had a hysterectomy?	☐	
☐ b.	Are your menstrual periods regular? Date of last menstrual period: _____	☐	
☐ c.	Ever have pain with your periods?	☐	
☐ d.	Do you have excessive bleeding during your period?	☐	
☐	1. Between periods?	☐	
☐	2. After sexual relations?	☐	
☐	3. After going through the “change of life”?	☐	
☐ e.	What type of birth control method are you using? (Check appropriate)	☐	
☐	1. None	☐	

NO		YES	COMMENT(S)
☐	2. Birth control pills	☐	
☐	3. IUD (Loop)	☐	
☐	4. Foam	☐	
☐	5. Diaphragm	☐	
☐	6. Condoms	☐	
☐	7. Tubes Tied	☐	
☐	8. Other: _____		
☐	f. Do you have a discharge now?	☐	
☐	g. When was your last Pap Smear?	☐	
	_____		
☐	h. Ever had an abnormal Pap smear?	☐	
☐	i. How many times have you been pregnant? _____		
☐	1. Full term _____	☐	
☐	2. Premature _____	☐	
☐	3. Miscarriages _____	☐	
☐	4. Abortions _____	☐	
☐	5. Are you pregnant now?	☐	
☐	j. Do you examine you breasts regularly?	☐	
☐	k. Ever found any lumps in your breasts?	☐	
☐	l. Ever had discharge from your nipples?	☐	
☐	m. Have you had the Measles, Mumps, and Rubella Vaccine (MMR) as an adult?	☐	

I certify that the foregoing information supplied by me is true and complete to the best of my knowledge.

Date	Signature of Patient	Signature of Person Reviewing History

TENNESSEE DEPARTMENT OF CORRECTION

REPORT OF PHYSICAL EXAMINATION

INSTITUTION: _____

NAME _____ **TDOC ID#:** _____ **DATE OF EXAM** _____

Blood Pressure (sitting): _____ Height: _____ Weight: _____ Temp: _____ Pulse: _____ Resp: _____

CLINICAL EVALUATION			
NORMAL	(Check each item in appropriate column; enter ***"NE"*** if not evaluated.)	**ABNORMAL**	**NOTES**: Describe every abnormality in detail. Enter pertinent item number before each comment. Use progress notes for additional information.
	1. GENERAL: Appearance, Nails, Skin, and Identifying Marks, Tattoos, etc.		
	2. EYES: General, Ophthalmoscopic; Pupils, and Ocular Motility		
	3. HEAD AND NECK		
	4. EARS: External and Otoscopic		
	5. MOUTH AND THROAT		
	6. NOSE AND SINUSES		
	7. LUNG AND CHEST		
	8. CARDIOVASCULAR: Heart and Vascular System		
	9. ABDOMEN: Inspection, Auscultation and Palpation		
	10. RECTUM AND ANUS: Hemorrhoids, Fistulae and Prostate, if indicated.		
	11. G.U. SYSTEM a. Genitalia b. Hernia		
	12. PELVIC		
	13. ENDOCRINE		
	14. MUSCULOSKELETAL SYSTEM: Spine, Upper Extremities and Lower Extremities		
	15. NEUROLOGICAL: Cranial Nerves, Motor Functions, Cerebella and DTR's		
	16. PSYCHIATRIC		

Summary of Defects/Conditions and Diagnosis continued on back. ☐

Advanced Directives

Inmate has been counseled and informed regarding Advance Directives ☐ (PH-4194 completed and placed in inmate health record)

An existing PH-4194, Advanced Care Plan, is on file and has been reviewed for updates ☐

HEALTH CLASSIFICATION BASED ON PHYSICAL EXAMINATION: _____

_____ _____

PRINTED NAME OF MEDICAL PROVIDER SIGNATURE OF MEDICAL PROVIDER

Duplicate as Needed

TENNESSEE DEPARTMENT OF CORRECTION

REPORT OF PHYSICAL EXAMINATION

Summary of Defects/Conditions and Diagnosis

Duplicate as Needed

TENNESSEE DEPARTMENT OF CORRECTIONS
URINALYSIS DIPSTICK RESULTS

Institution:_____

NAME_____ TDOC ID_____

DATE_____ Time: _____

Type of dipstick: _____

TEST RESULTS

RESULTS- CIRCLE APPROPRIATE READING

APPEARANCE		CLEAR		CLOUDY		SEDIMENT		
COLOR	YELLOW	AMBER	PINK	ORANGE	BLUE	GREEN	BROWN	RED
LEUKOCYTES	NEG	15+	70+	125++	500+++			
NITRATE	NEGATIVE		POSITIVE	(Any degree of pinkish color) **See Strip Bottle				
UROBILLINOGEN	NEG	TRACE	0.2(3.5)	1 (17)	2(35)	4(70)	8(140)	12(200)
PROTEIN	NEG	15(0.15)	30(0.3)$^{+}$	100(1.0)$^{++}$	300(3.0)$^{+++}$	2000(20)$^{++++}$		
PH	5.0	6.0	6.5	7.0	7.5	8.0	9.0	
BLOOD	NEG	TRACE (+/-)	+	++	+++	5-10	50	
SPECIFIC GRAVITY	1.000	1.005	1.010	1.015	1.020	1.025	1.030	
KETONE	NEG	5(0.5)$^{+}$	15(1.5) $^{++}$	40(4.0)$^{++}$	80(8.0) $^{+++}$	160(16)$^{++++}$		
BILLIRUBIN	NEG	1(17)$^{+}$	2(35)$^{++}$	4(70)$^{+++}$				
GLUCOSE	NEG	100(5)+/-	250(15)$^{+}$	500(30)$^{++}$	1000(60)$^{+++}$	2000 or more (110) $^{++++}$		

Nurse completing reading: _____
Provider reviewing results: _____ Date:_____

CR4186 Duplicate As Needed RDA####

TENNESSEE DEPARTMENT OF CORRECTION
HEALTH SERVICES
REFUSAL OF MEDICAL SERVICES

INSTITUTION: _____

Date _____ 20 _____ Time _____ AM/PM

This is to certify that I _____ (Inmate's Name), _____ (TDOC ID)

have been advised that I have been scheduled for the following medical services and/or have been advised to have the following evaluations, treatment, or surgical/other procedures:

_____

_____

_____

I am refusing the above listed medical services against the advice of the attending physician and/or the Health Services staff. I acknowledge that I have been informed of the risks involved by my refusal and hereby release the State of Tennessee, Department of Correction, and their employees from all responsibility for any ill effects which may be experienced as a result of this refusal. I also acknowledge this medical service may not be made readily available to me in the future unless an attending physician certifies my medical problem as a medical emergency.

Signed: _____ _____ _____
(Inmate) (TDOC ID) (Date)

Witness: _____ _____ _____
(Signature) (Title) (Date)

The above information has been read and explained to,

_____ _____ but has refused to sign
(Inmate's Name) (TDOC ID)
the form.

Witness: _____ _____ _____
(Signature) (Title) (Date)

Witness: _____ _____ _____
(Signature) (Title) (Date)

TENNESSEE DEPARTMENT OF CORRECTION
HEALTH SERVICES

MAJOR PROBLEM LIST

_____
INSTITUTION

Name: _____ TDOC ID: _____
Last First Middle

Date of Birth: _____ Gender: ☐ M ☐ F Race: _____

Allergies: _____

PROBLEM NUMBER*	DATE IDENTIFIED/ RECORDED	MAJOR CLINICAL CONDITIONS/PROBLEMS	RESOLVED *(Please check "√" if resolved)*	RESOLVE DATE

Conservator Name: _____

Primary Phone: _____ Secondary Phone: _____

* Major medical problems considered medical or surgical in nature are identified by Roman numerals, i.e., **I** – Diabetes, **II** – Laminectomy.
* Psychiatric, or serious psychological problems, are identified by capital letters, i.e., **A** – Schizophrenia, **B** – Self-Mutilative Behavior.

TENNESSEE DEPARTMENT OF CORRECTION
HEALTH RECORDS/MEDICATION MOVEMENT

DESTINATION: _____

THIS PACKET CONTAINS HEALTH RECORDS ON THE FOLLOWING INMATE(S):

CHECK ALL THAT APPLY

	Inmate Name	TDOC ID	Health Record	Dental Record	Medication	* Purpose (**A, B, C** or **D**)	# of Volumes
1.			☐	☐	☐		
2.			☐	☐	☐		
3.			☐	☐	☐		
4.			☐	☐	☐		
5.			☐	☐	☐		
6.			☐	☐	☐		
7.			☐	☐	☐		
8.			☐	☐	☐		
9.			☐	☐	☐		
10.			☐	☐	☐		
11.			☐	☐	☐		
12.			☐	☐	☐		
13.			☐	☐	☐		
14.			☐	☐	☐		
15.			☐	☐	☐		

*** PURPOSE OF RECORDS MOVEMENT:**

A. Permanent Transfer **B.** Temporary Transfer for Clinical Services **C.** Record to Archives **D.** Other (*See Comments*)

Comments: _____

_____

_____

Sending Institution: _____

Clinical Services Signature: _____

***** THIS DOCUMENT SHALL NOT CONTAIN PROTECTED HEALTH INFORMATION *****

White-Exterior Packet **Canary**-Exterior Packet **Pink**-Inside Records Packet **Goldenrod**-Sending Institution Medical Records Office

TENNESSEE DEPARTMENT OF CORRECTION

TRANSFER/DISCHARGE HEALTH SUMMARY

Name of Inmate: _____ TDOC ID: _____

_____ Gender: ☐ Male ☐ Female

Current Institution/County/Facility: _____ Receiving Institution/County/Facility:

Reason for Transfer/Discharge: _____

Requires Chronic Illness Monitoring: ☐ Yes ☐ No Requires Mental Health/Psychiatric Monitoring? ☐ Yes ☐ No

HEALTH HISTORY *Check (√) all conditions present*

☐ HIV/AIDS	☐ Depression	☐ Hernia	☐ Prosthesis *(specify)* _____
☐ Alcoholism	☐ Diabetes	☐ High Cholesterol	☐ Rheumatoid Arthritis
☐ Anemia	☐ Emphysema	☐ Hypertension	☐ Stroke
☐ Asthma	☐ Epilepsy	☐ Kidney Disease	☐ Suicide Attempt/Gesture/Ideation
☐ Cancer *(specify)* _____	☐ Heart Disease	☐ Liver Disease	☐ Tuberculosis
☐ Chemical Dependency	☐ Hepatitis C	☐ Multiple Sclerosis	☐ Venereal Disease
☐ COPD	☐ Other *(specify)*: _____		

MH Diagnosis(s): _____

MEDICATION ORDERS

NAME OF DRUG	STRENGTH/ROUTE	FREQUENCY	LAST DOSE DATE/TIME	MEDICATION SENT *(Circle Y/N)*	AMOUNTS SENT	KOP *(Circle Y/N)*
				Yes No		Yes No
				Yes No		Yes No
				Yes No		Yes No
				Yes No		Yes No
				Yes No		Yes No
				Yes No		Yes No
				Yes No		Yes No
				Yes No		Yes No

Brief Summary of Current Problems/Diagnosis(s): _____

Special Instructions (e.g. Allergies, Diet, Impairments, Medical Appointments, etc.): _____

Referred to Community Resources: ☐ Yes ☐ No Specify: _____

TB INFORMATION

TB Clearance ☐ Y ☐ N; BCG ☐ Y ☐ No; PPD Completed: ___/___/___ Results: _____ CXR Completed ___/___/___

Health Authority Clearance: ___/___/___

_____ _____ _____

Name Title Date

SPECIAL INSTRUCTIONS/PRECAUTIONS

Inmate is on Suicide Monitoring or Special Mental Health Observation: ☐ **Yes** ☐ **No** **Dates:** _____

Is Inmate medically able to travel by BUS, CAR, or VAN?	☐ Yes	☐ No
Does the inmate require medication during transport?	☐ Yes	☐ No
Does the inmate require medical equipment during transport?	☐ Yes	☐ No
Does the inmate have communicable disease clearance to travel?	☐ Yes	☐ No
Is the Transport Officer required to use universal precautions and the use of masks or gloves?	☐ Yes	☐ No

Conservator: ☐ Yes (list information below) ☐ No (If no, list Emergency Contact)

Name: _____ Address: _____ Phone: _____

Report prepared by: _____ _____

Health Signature/Professional Title Date

Report prepared by: _____ _____

Mental Health Signature/Professional Title *(if applicable)* Date

Receiving Institution: _____ _____

Signature/Professional Title Date

TENNESSEE DEPARTMENT OF CORRECTION

COMPREHENSIVE CLINICAL RECORD REVIEW

_____
INSTITUTION

INMATE NAME: _____ TDOC ID: _____

Health Services Review:

Applicable Items identified as complete:

☐ Advance Directives

☐Conservatorship

☐Major Problem List, CR-1894- Diagnosis Current/Resolved

☐Chronic Disease Clinic Treatment Plan, CR-3624

☐Medication orders/renewed

☐Teaching /Counseling Plan, CR-2742

☐Immunization/TB Control Record, CR-2217

☐Inmate/Employee Tuberculosis Screening Tool CR-3628

☐Health Classification Summary, CR-1886

☐Report of Physical Examination, CR-3885

☐Health History, CR-2007

☐Progress Notes

☐Signatures/dates/full legible

☐CR-2178

Behavioral Health Services Review:

Applicable Items identified as complete:

Major Problem List-CR-1894

☐LOC ☐Diagnosis Current/Resolved

☐Treatment Plan

☐Medication orders/ renewed

☐Consent

☐Mental Health Evaluation

☐Referrals

☐Annual Psychiatrist Review

☐Intrasystem Transfers signed within 14 days

☐Signatures/dates full/legible

☐CR-4050

_____ _____
Health Services Administrator/Designee Date

_____ _____
Behavioral Health Services Administrator/Designee Date

Tennessee Department of Health
Division of Health Licensure and Regulation
Office of Health Care Facilities
665 Mainstream Drive, Second Floor
Nashville, TN 37243
www.tn.gov/health

ADVANCE CARE PLAN
(Tennessee)

I, _____, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

Agent: I want the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Phone #: (___)_____ Relation: _____
Address: _____

Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Phone #: (___)_____ Relation: _____
Address: _____

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

When Effective (mark one):

☐ I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself.
☐ I do not give such permission (this form applies only when I no longer have capacity).

Quality of Life: By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "**no**" below, I have indicated conditions I would not be willing to live with (that to me would create an **unacceptable** quality of life).

☐ Yes ☐ No	**Permanent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
☐ Yes ☐ No	**Permanent Confusion:** I become unable to remember, understand, or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
☐ Yes ☐ No	**Dependent in all Activities of Daily Living:** I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
☐ Yes ☐ No	**End-Stage Illnesses:** I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is needed most of the time and activities are limited due to the feeling of suffocation.

Treatment: If my quality of life becomes unacceptable to me (as indicated by one or more of the conditions marked "no" above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "**no**" below, I have indicated treatment I **do not want**.

☐ Yes ☐ No	**CPR (Cardiopulmonary Resuscitation):** To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
☐ Yes ☐ No	**Life Support / Other Artificial Support:** Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys, and other organs to continue to work.
☐ Yes ☐ No	**Treatment of New Conditions:** Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
☐ Yes ☐ No	**Tube feeding/IV fluids:** Use of tubes to deliver food and water to a patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.

Please sign on page 2

Other instructions, such as burial arrangements, hospice care, etc.: _____

_____

_____

_____

(Attach additional pages if necessary)

Organ donation: Upon my death, I wish to make the following anatomical gift (mark one):

☐ Any organ/tissue ☐ My entire body ☐ Only the following organs/tissues: _____

_____

☐ No organ/tissue donation

SIGNATURE

Your signature must **either** be witnessed by two competent adults **or** notarized. If witnessed, neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must be someone who is not related to you or entitled to any part of your estate.

Signature: _____ DATE: _____
(Patient)

Witnesses:

1. I am a competent adult who is not named as the agent. I witnessed the patient's signature on this form.

_____
Signature of witness number 1

2. I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

_____
Signature of witness number 2

This document may be notarized instead of witnessed:

STATE OF TENNESSEE

County of _____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient." The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

Notary Public: _____
Signature

My commission expires: _____

WHAT TO DO WITH THIS ADVANCE DIRECTIVE

- Provide a copy to your physician(s)
- Keep a copy in your personal files where it is accessible to others
- Tell your closest relatives and friends what is in the document
- Provide a copy to the person(s) you named as your health care agent