

MEDICAL/SURGICAL AND PSYCHIATRIC REFERRAL REQUEST

TO: OMDT, CENTRAL OFFICE		EMAIL: BOP-HSD/MEDICAL DESIGNATIONS	PHONE: (202) 514-9780
Date:	Institution:		
INMATE NAME: (Last)	(First)	(MI)	REG. NO.:
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female			Date of Birth: Age:
Prepared by: (MD, PhD, HSA)			Phone:
Name of Referring Physician or Psychologist:			Phone:
Reviewed and Approved by CD:	Date:	Phone:	
(Must be completed for psychiatric and medical referrals)			
Approved By: (Warden)			Date:
Referral Type: <input type="checkbox"/> EMERGENCY	<input type="checkbox"/> ROUTINE-URGENT	<input type="checkbox"/> ROUTINE	
Has patient signed a consent for treatment: <input type="checkbox"/> YES <input type="checkbox"/> NO (Not required for Mental Health or involuntary treatment)			
Is required treatment available in local community: <input type="checkbox"/> YES <input type="checkbox"/> NO If not, please explain:			
Principle reason for referral to (check one): <input type="checkbox"/> MRC Med/Surg (Please specify: <input type="checkbox"/> LTC <input type="checkbox"/> PT <input type="checkbox"/> SURG <input type="checkbox"/> ONC) <input type="checkbox"/> MRC MH <input type="checkbox"/> Axis II Program			
Diagnoses: (For MH use current DSM criteria for Axis I, II, and <u>III</u>)			
SMD Code:			
HT: _____ ft. _____ in.	WT: _____ lbs.	Significant <input type="checkbox"/> gain	<input type="checkbox"/> loss _____ lbs.

NARRATIVE SUMMARY: (Include symptoms and duration, past relevant hospitalizations at MRCs, consultations/procedures, est. duration of treatment, relevant laboratory data, diagnostic procedures required, completed tests and results, X-Ray studies, and proposed treatment goals.)

MELD SCORE: ____ (Chronic liver disease referrals only)

Current Medications (List ALL and doses):

Compliant with regimen: YES NO

Sex: Male Female

Date of Birth: _____ Age: _____

Special medical equipment in-transit: (All durable medical goods must accompany the inmate to the designated facility.)

wheelchair walker cane crutches C-pap Other:

MEDICAL ISSUES:

Currently hospitalized: YES NO Date: _____

Stable for transfer: YES NO

IV required

Assistance with ADLs required

Hospice

Long-term treatment/rehabilitation

Physical therapy

Incontinent

Wound care

Drug withdrawal

Seizures

Oxygen

Cardiac monitoring

Diabetic care

Sickle Cell

Allergic reaction: (specify)

PSYCHIATRIC ISSUES: (For MRC MH referrals only. For Step-down referrals, please utilize transfer form in guidelines. For Axis II referrals, skip this section)

The inmate has a valid DSM Axis I diagnosis and meets at least one of the following criteria from A and one from B (check all that apply):

A. Dangerousness (check all that apply)

- Exhibits suicidal or self harm thoughts or behaviors secondary to a psychiatric illness other than antisocial or borderline personality disorder
- Exhibits homicidal or assaultive thoughts or behaviors, secondary to a psychiatric illness other than antisocial or borderline personality disorder
- Manifests, or will soon manifest, severe deterioration in functioning secondary to a psychiatric illness other than antisocial or borderline personality disorder

- Acute impairment in ability to function socially or in basic activities of daily living
- Currently experiencing psychiatric symptoms intolerable to self or extremely disruptive to the correctional environment
- Aggressive outpatient therapy has failed. Please describe:
- Due to complex presentation, psychiatric hospitalization is necessary for evaluation and/or diagnosis. Please describe:
- Involuntary commitment may be needed due to inmate noncompliance and severe mental illness

B. Emergency medication has been considered, and (check one):

- Inmate does not meet the criteria of being gravely disabled or being a danger to self or others
- Emergency medication was given on _____ (date), but the inmate continues to refuse voluntary medication and/or remains acutely and severely mentally ill.

RECOMMENDED MODE OF TRAVEL	<input type="checkbox"/> Commercial air
<input type="checkbox"/> Air ambulance	<input type="checkbox"/> Institution vehicle
<input type="checkbox"/> Air charter	<input type="checkbox"/> BOP/USM airlift
<input type="checkbox"/> Ground ambulance	<input type="checkbox"/> BOP bus
S/L: ___Min ___Low ___Med ___High	CUS: ___Com ___Out ___In ___Max

Current Offense/Charge:

Projected Release Date:

CIMS Considerations: (Pending incident reports, separatees, threat group affiliations, etc.)

FOR USE BY OMDT:

APPROVED MRC REQUIRED:

Projected length of stay: _____ days _____ months

DENIED Comments:

Distribution: Medical File - informational copy, Central File - completed copy, OMDT