BP-A770.060
FEB 05

U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF PRISONS

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: ☐ Male ☐ Female	Date of Birth: Age:
Prepared by: (MD, PhD, HSA)	Phone:
Name of Referring Physician or Psychologist:	Phone:
Reviewed and Approved by CD: Date: (Must be completed for psychiatric and medical referrals)	Phone:
Approved By: (Warden)	Date:

Referral Type: ☐ EMERGENCY ☐ ROUTINE-URGENT ☐ ROUTINE

Has patient signed a consent for treatment: ☐ YES ☐ NO
(Not required for Mental Health or involuntary treatment)

Is required treatment available in local community: ☐ YES ☐ NO
If not, please explain:

Principle reason for referral to (check one):

☐ MRC Med/Surg (Please specify: ☐ LTC ☐ PT ☐ SURG ☐ ONC)
☐ MRC MH
☐ Axis II Program

Diagnoses: (For MH use current DSM criteria for Axis I, II, and III)

SMD Code:

HT:_____ft._____in. WT:_____lbs.	Significant ☐ gain ☐ 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 mediation was given on _____(date), but the inmate continues to refuse voluntary medication and/or remains acutely and severely mentally ill.

RECOMMENDED MODE OF TRAVEL	☐ Commercial air
☐ Air ambulance	☐ Institution vehicle
☐ Air charter	☐ BOP/USM airlift
☐ Ground ambulance	☐ 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

(This form may be replaced via WP) This form replaces BP-S770 dtd JAN 03