

**HEALTH CARE SERVICES REQUEST FORM (PBSP 7362)**

<b>PART I: TO BE COMPLETED BY THE PATIENT</b>			
If you believe this to be an urgent/emergent health care need, contact the correctional officer on duty			
REQUEST FOR: MEDICAL <input type="checkbox"/> PSYCHIATRY <input type="checkbox"/> MENTAL HEALTH <input type="checkbox"/> DENTAL <input type="checkbox"/> PHARMACY <input type="checkbox"/>			
NAME:	CDC #:	HOUSING:	
PHARMACY REFILL #	*Pharmacy, place labels on back of form*		
THE REASON YOU WANT HEALTH CARE. (DESCRIBE YOUR HEALTH PROBLEM AND HOW LONG YOU HAVE HAD THE PROBLEM)			
PATIENT'S SIGNATURE:		DATE:	
<b>PART II: TO BE COMPLETED BY THE TRIAGE RN/RDA/MTA</b>			
Date & Time Received:		Received by:	
Reviewed by RN/RDA, Date:	Time:	Signature:	Triage Designation:
<b>S:</b>			
<b>O:</b>	<b>T:</b>	<b>P:</b>	<b>R:</b>
<b>BP:</b>	<b>WEIGHT:</b>		
<b>A:</b>			
<b>P:</b>			
Signature/Date/Time:			
APPOINTMENT SCHEDULED AS:	EMERGENCY <input type="checkbox"/> (immediately)	URGENT <input type="checkbox"/> (within 24 hours)	ROUTINE <input type="checkbox"/> (within 14 calendar days)
REFERRED TO PCP:	DATE OF APPOINTMENT:		
Print/Stamp Name	Signature/Title	Date & Time Completed	
<b>COPAYMENT INFORMATION - TO BE FILLED OUT BY DEPARTMENTAL STAFF</b>			
1.	<input type="checkbox"/>	Visit was for an emergency	
2.	<input type="checkbox"/>	Visit was for diagnosis or treatment of a communicable disease condition (Sec Title 17, Chapter 4, Subchapter 1, Section 2500 CCR)	
3.	<input type="checkbox"/>	Visit was for mental health services	
4.	<input type="checkbox"/>	Visit was a follow-up requested by the clinician.	
5.	<input type="checkbox"/>	Visit was for State mandated evaluation or treatment (e.g., Annual TB tests)	
6.	<input type="checkbox"/>	Visit was for reception screening and evaluation only	
7.	<input type="checkbox"/>	Visit is NOT exempt from co-payment. Send PINK copy to Inmate Trust Office.	
<b>DISTRIBUTION:</b>			
ORIGINAL - Unit Health Record PBSP 7362 (Rev. 7.03)	YELLOW - Pharmacy	PINK - Inmate Trust	GOLDENROD - Inmate/Patient
<b>Name:</b>	<b>CDC#:</b>	<b>Housing:</b>	<b>Institution:</b>