HENDRY COUNTY SHERIFF'S OFFICE
DETENTION DIVISION
MEDICAL/PREA INTAKE SCREENING FORM

NAME ____ SEX ______ RAC ______ DOB __/__/___
LAST FIRST MI
SSN _____-_____-_____ DATE ___/___/____ TIME _______ **AM/PM**
JAIL BEFORE **YES/NO, WHERE** ____________________
MEDICAL INSURANCE **YES/NO** IF YES, WITH WHO ____

VISUAL OBSERVATION **CIRCLE ONE**
ANY YES ANSWERS REQUIRE A DETAILED EXPLANATION ON THE BACK OF THIS FORM

1. IS THE INMATE UNCONSCIOUS ____ YES NO
2. DOES THE INMATE HAVE OBVIOUS PAIN, TRAUMA, ILLNESS, OR OTHER SYMPTOMS SUGGESTING NEED FOR IMMEDIATE EMERGENCY OR DOCTORS CARE ____ YES NO
3. DOES THE INMATE EXHIBIT ANY SIGNS OF ABNORMAL BEHAVIOR_______ YES NO
4. IS THERE FEVER, SWOLLEN LYMPH NODES, JAUNDICE OR EVIDENCE OF INFECTIONS WHICH MIGHT SPREAD THROUGH THE JAIL _______________ YES NO
5. IS THERE EVIDENCE OF VERMIN OR POOR SKIN _______________________ YES NO
6. DOES THE INMATE APPEAR TO BE UNDER THE INFLUENCE OF ANY KNOWN SUBSTANCE (ALCOHOL AND/OR DRUGS) ___________________ YES NO
7. ARE THERE ANY SIGNS OF ALCOHOL OR DRUG WITHDRAWAL SYMPTOMS ____ YES NO
8. DOES THE INMATES BEHAVIOR AND/OR PHYSICAL APPEARANCE SUGGEST THE RISK OF SUICIDE ____ YES NO
9. DOES THE INMATES BEHAVIOR SUGGEST THE RISK OF ASSAULT TO STAFF OR OTHER INMATES ____ YES NO
10. IS THE INMATE CARRYING MEDICATION OR DOES HE REPORT BEING ON MEDICATION WHICH SHOULD BE ADMINISTERED OR AVAILABLE ________ YES NO
11. DOES THE INMATE HAVE CUTS OR ABRASIONS THAT WERE NOT SERIOUS ENOUGH TO WARRANT MEDICAL ATTENTION (NOT MENTIONED IN ITEM #2) ____ YES NO
12. DOES THE INMATE APPEAR TO NEED DENTAL SCREENING _______________ YES NO
13. DOES THE INMATE SHOW ANY WARNING SIGNS FOR RISK OF SEXUAL ABUSE SUCH AS; SMALL BUILD, YOUNG AGE, MENTAL OR PHYSICAL DISABILITIES, FIRST TIME OFFENDER OR SEXUAL ORIENTATION THAT COULD PLACE THEM AT RISK OF BEING SEXUALLY ASSAULTED DURING THEIR INCARCERATION? ____ YES NO

INMATE QUESTIONNAIRE

14. ARE YOU TAKING MEDICATION FOR DIABETES, HEART DISEASE, SEIZURES, ASHMA, ULCERS, HIGH BLOOD PRESSURE, OR A PSYCHIATRIC DISORDER____ YES NO
15. DO YOU HAVE OR HAVE YOU EVER HAD TUBERCULOSIS, DIABETES, HEPATITIS OR EPILEPSY____ YES NO
16. DO YOU HAVE A SPECIAL DIET PRESCRIBED BY A PHYSICIAN ___________ YES NO
17. DO YOU HAVE OR HAVE YOU EVER HAD A VENEREAL DISEASE OR ABNORMAL DISCHARGE ____ YES NO
18. HAVE YOU RECENTLY BEEN HOSPITALIZED FOR ANY MEDICAL OR PSYCHIATRIC ILLNESS ____ YES NO
19. HAVE YOU EVER BEEN TREATED FOR A MENTAL DISORDER (INCLUDE

TYPE AND WHEN ON BACK OF FORM) ______________________ YES NO

20. IF CURRENTLY BEING TREATED FOR A MENTAL DISORDER, DO YOU FEEL LIKE YOU WANT TO HARM YOURSELF OR SOMEONE ELSE ________ YES NO
21. HAVE YOU EVER BEEN THE VICTIM OF SEXUAL ABUSE OR RAPE (IF YES, HOW LONG AGO) ______________________ ______ YES NO
22. DO YOU CURRENTLY FEEL YOU ARE VULNERABLE OF BEING SEXUALLY ASSAULTED OR ABUSED? ______________________ YES NO
23. DO YOU HAVE A CONTAGIOUS/COMMICABLE DISESASE ______________ YES NO
24. ARE YOU ALLEGIC TO ANY MEDICATION OR FOOD ________________ YES NO
25. HAVE YOU FAINTED RECENTLY OR HAD A HEAD INJURY (WHEN) ______ YES NO
26. DO YOU HAVE A PAINFUL DENTAL CONDITION ____________________ YES NO
27. (IF FEMALE) ARE YOU PREGNANT ______________________________ YES NO
28. (IF FEMALE) ARE YOU ON BIRTH CONTROL ______________________ YES NO
29. (IF FEMALE) HAVE YOU RECENTLY DELIVERED OR ABORTED________ YES NO
30. DO YOU HAVE ANY OTHER MEDICAL PROBLEMS THAT WE SHOULD BE AWARE OF ______________________________________ YES NO
31. DO YOU USE ALCOHOL______________________________________ YES NO
32. DO YOU USE DRUGS ____ YES NO

IF YES TO QUSETIONS 31, 32 – SPECIFY QUANTITY/FREQUENCY, DATE AND TIME OF MOST RECENT USE ____

*************NOTE: ALL OTHER YES ANSWERS REQUIRE A DETAILED ANSWER HERE**************

ANSWER THE FOLLOWING QUESTIONS FOR INJURIES THAT REQUIRE EMS OR HOSPITALIZATION
WHEN DID THE INJURY OCCUR: ANSWER EACH QUESTION AND EXPLAIN WHERE NECESSARY

1. PRIOR TO THE ARREST (I.E. 1 DAY/2 DAYS, ETC) YES NO
2. DURING THE ARREST YES NO
3. IN THE JAIL YES NO

EXPLANATION OF INJURY:

____

PLACEMENT OF RECOMMENDATION: (CHECK ONE) GENERAL POPULATION ________
IMMEDIATE MEDICAL REFERRAL ____ LATER MEDICAL REFERRAL_____ ISOLATION _____

EMERGENCY CONTACT INFORMATION

NAME ______________________________ RELATIONSHIP _______________

ADDRESS____

PHONE # ______________________________

______________________ INMATE'S SIGNATURE

______________________ INTERVIEWER'S SIGNATURE