

INMATE MEDICATION INFORMATION FORM

INMATE INFORMATION

FULL LEGAL NAME OF INMATE: _____

STREET ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

DOB: _____

BOOKING _____

JAIL LOCATION: _____ FLOOR: _____

FAMILY CONTACT INFORMATION

FAMILY CONTACT NAME: _____ RELATIONSHIP _____

STREET ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

DAYTIME PHONE: _____ EVENING PHONE: _____

CONTACT SIGNATURE:
x _____

PSYCHIATRIST/TREATMENT FACILITY INFORMATION

PSYCHIATRIST/LAST TREATMENT FACILITY: _____ DATE LAST TREATED: _____

STREET ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

PHONE: _____ FAX: _____

MEDICAL INFORMATION

DIAGNOSIS: _____

DAYTIME MEDICATIONS: _____

NIGHTTIME MEDICATIONS: _____

PRIOR ADVERSE MEDICATION EFFECTS (i.e. side effects, allergies, poor efficacy):

IS SUICIDE A CONCERN? NO _____ YES _____ IF YES, WHY?

OTHER MEDICAL CONCERNS: _____

MEDICAL DOCTOR'S NAME: _____ OFFICE PHONE: _____

STREET ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

JAIL PSYCHIATRIC SERVICES (JPS)

EITHER CALL THIS INFORMATION IN TO JPS AT (916) 874-5222 OR FAX THIS FORM TO 916-874-8143