INMATE MEDICATION INFORMATION FORM

Please use this form to provide Custody Health Services with information about an inmate's medical, mental health, medication, and other health concerns or issues.

INFORMATION ABOUT THE INMATE

FULL LEGAL NAME OF INMATE: _____

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

DATE OF BIRTH: _____ BOOKING NUMBER: _____

JAIL LOCATION: _____ HOUSING: _____

FAMILY CONTACT INFORMATION

FAMILY CONTACT NAME:_____ RELATIONSHIP: _____

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

DAYTIME PHONE: _____ EVENING PHONE: _____

PSYCHIATRIST/TREATMENT FACILITY INFORMATION

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

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

PHONE: _____ FAX: _____

MEDICAL INFORMATION

DIAGNOSIS: _____

DAYTIME MEDICATION(S): _____

NIGHT TIME MEDICATION(S): _____

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: _____

PLEASE FAX THE COMPLETED FORM TO THE FACILITY WHERE THE INMATE IS HOUSED:
MAIN JAIL: (408) 808-5245 ● **ELMWOOD:** (408) 946-8023

INMATE HOUSING INFORMATION IS AVAILABLE AT: https://eservices.sccgov.org/OVR/FindInmate/Find