### TITLE 47 SCREEN

**Use standard precautions when screening all new detainees**

**PRE-BOOKING SCREEN**  Completed prior to booking into DOC custody

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the detainee unconscious or unable to be roused with voice or physical stimulation?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the detainee have obvious pain, bleeding, signs of trauma or illness suggesting immediate need for emergency service?</td>
<td></td>
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<tr>
<td>Exclusive of disability, is the detainee unable to stand and walk with one person offering minimal assistance?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BRAC:**

- Time: 

Any YES answer to above questions - notify remanding officer that a written medical discharge note from local hospital is required prior to booking into DOC custody.

**DETAINEE SEEN AT LOCAL MEDICAL FACILITY PRIOR TO BOOKING?** (If YES, complete the following questions)

<table>
<thead>
<tr>
<th>Name of Facility</th>
<th>Date &amp; Time of Visit</th>
<th>Sent by DOC?</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Reason for visit &amp; treatment received</th>
<th>Date &amp; Time of Visit</th>
<th>Condition stabilized prior to return?</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Written ER note including discharge paperwork obtained and placed in medical record?</th>
<th>Date &amp; Time of Visit</th>
<th>Condition stabilized prior to return?</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

**POST-BOOKING OBSERVATION**  Completed immediately after booking by medical staff or security staff when no medical staff on duty.

- Are there any obvious physical impairments?  YES | NO |

| Does the detainee appear to be under the influence of alcohol? Smell of alcohol on breath? | YES | NO |
| Does the detainee appear to be under the influence of any drug? YES NO | Describe: |
| *Are there visible signs or symptoms of alcohol or drug withdrawal? | YES | NO |
| Is there evidence of contagious or infectious health conditions that may spread throughout the institution? | YES | NO |

- Lice YES/NO | Location
- Rash YES/NO Location
- *Open or draining wounds? YES/NO | Location
- *Fever YES NO | *Chills YES NO
- *Cough YES NO | *Vomiting YES NO
- *Sore Throat YES NO | *Diarrhea YES NO

- Did detainee arrive with prescribed medications? YES | NO

- *Does detainee report prescribed medications that must be taken prior to medical staff on duty? YES | NO

Call Provider for all “YES” answers to questions preceded by an asterisk *. Isolate detainee & call provider for all “YES” responses to feeling ill AND reporting symptoms of contagious conditions. (Medical staff initiates Complaint Specific Nursing Protocol.) Document provider contact at bottom of page.

**SUICIDE RISK FACTORS**  Completed immediately after booking by medical staff or security staff when no medical staff on duty.

- Is this your first time in jail?  YES | NO

| Are you thinking of killing yourself? YES response to this question requires immediate suicide precautions & referral to Mental Health. | YES | NO |
| Have you ever thought about killing yourself? | YES | NO |
| Has anyone in your family ever committed suicide? | YES | NO |
| Have you ever attempted to kill yourself? | YES | NO |

- If YES, how many times Method?

- When was most recent time?

- Have you experienced a recent significant loss?  YES | NO

- Have you ever been diagnosed with depression?  YES | NO

- Does detainee appear overly embarrassed, ashamed or guilty about accused crime?  YES | NO

3 or more YES responses require referral to mental health, greater than 5 YES responses also requires immediate suicide precautions.

Completed by:

**Provider contacted:** _____________ **Date & Time:** _____________

**Orders/Directions received:** ____________________________

**Signature:** ____________________________
TITLE 47 SCREEN

VITAL SIGNS

Temperature: Pulse: Respiration: B/P: O₂ Sat: Weight: BRAC:

ALLERGIES: (Indicate all allergies)

Detainee uncooperative/Unable to complete screen? Yes No
Uncooperative Detainee Protocol initiated? Yes No

Are you wearing or do you regularly use contacts, glasses, hearing aid, prosthetics, dentures, crutches, cane or any other medical device? Yes No
Do you have your medical device with you? Yes No

Additional information:

Have you recently been injured? Yes / No (Please circle) traffic accident head injury fight other:
Type of injury:

Do you have any other medical conditions we should know about? Yes No

Medical treatment prior to incarceration? List current treatment and recent surgeries.

Alcohol and Drug Screen

Alcohol use: Type and amount used daily? Have you ever been ill with Tuberculosis? Yes No
Number of drinks last 24 hr? How long ago?

Drug use: Type and amount used daily? Have you recently been around someone with TB? Yes No
Amount and Time of last dose?

Do you have problems that occur after stopping the use of drugs or alcohol? Y / N

Explain:

Tuberculosis Screen

Have you recently been around someone with TB? Yes No

Do you currently have:

- Productive cough for more than two weeks? Yes No
- Night sweats? Yes No
- Recent unexplained weight loss? Yes No
- Coughing up blood? Yes No
- Unexplained fatigue? Yes No

Orientation: Person Place Time Disoriented

Thought process: Can form sentence: Yes No

Conversation appropriate: Yes No

Agitation: Normal activity Restless Pacing/Thrashing

Comments:

REPORTED MEDICATIONS: Has medications with them? YES / NO □ ROI sent □ Placed in Tamper Proof Envelope #:

Record medication history as reported by detainee. Follow policy 807.05 for handling personal medications brought to facility.

Date Time Notes/Observations Initials

General appearance:

Medical Referral Yes No Reason:

Provider Contacted: Date: Time:

Mental Health Referral Yes No

Professional Contacted: Date: Time:

Language Barrier? Yes No

Completed by: Date Time

Date & Time of Release: