STANISLAUS COUNTY INMATE MEDICATION INFORMATION FORM

Full Legal Name____Date of Birth________________

AKA's/Nickname____SS#____________________

Street Address____City/State/Zip________________

If Homeless, County Last Resided in?____

Booking #______________________________Jail Location______________________________

FAMILY CONTACT INFORMATION

Family Contact Name____Relationship________________

Street Address____City/State/Zip________________

Daytime Phone #________________Evening Phone #________________Fax #____________________

Contact Signature____

PSYCHIATRIST / TREATMENT FACILITY INFORMATION

Psychiatrist / Last Treatment Facility______________________________Date Last Treated____________

Street Address____City/State/Zip________________

Daytime Phone #____Fax #____________________

MENTAL HEALTH AND MEDICAL INFORMATION

Diagnosis____

List Medications, Dose & Frequency____

____

Prior Adverse Medication Effects (i.e. side effects, allergies, poor efficacy)________________________

Are you concerned that inmate may harm himself?________Yes_______No

Why?____

____

Previous Attempts/Method____

____

Other Medical Concerns

____

Medical Doctor's Name______________________________Office Phone #____________________

Other Medications:____

Additional Information:____

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FAX FORM TO STANISLAUS COUNTY PSYCHIATRIC SERVICES: Fax# 209-525-5623 Monday-Friday; 209-525-5673 Weekends, (Message Phone: 209-525-5622)