Medical Information Form

The purpose of this form is to provide a method for family members/significant others to communication with medical staff at the **Johnson County Adult Detention Center (ADC)** about their loved one's mental health history. **Completing this form is voluntary; it is not required. Further, all questions do not have to be answered.**

This information will be kept in medical records as a hard copy (paper copy) only and must be re-submitted each time a person is incarcerated. Medical providers are prohibited from giving medical information to family members/significant others without authorization from the person in jail. However, treatment providers may receive information from family members/significant others.

Important – ALL medical and mental health treatment decisions, as well as prescription medication decisions for the inmate, shall be made by a VitalCore Health Strategies physician or psychiatrist after reviewing and/or verifying information on the form.

The completed form may be mailed, faxed, or hand-delivered to the ADC. Fax to 913-715-5979; mail to Medical Staff, VitalCore Health Strategies 27745 W 159th St., New Century, KS 66031. You may hand-deliver to the ADC located at 27745 W 159th St. New Century, KS 66031.

DATE:

FULL NAME (of person at ADC):

STREET ADDRESS: CITY:

STATE: ZIP CODE: DOB: PHONE:

EMERGENCY CONTACT INFORMATION

NAME of EMERGENCY CONTACT:

RELATIONSHIP:

DAYTIME PHONE: EVENING PHONE:

NAME of ALTERNATIVE EMERGENCY CONTACT:

RELATIONSHIP:

DAYTIME PHONE: EVENING PHONE:

PSYCHIATRIST/TREATMENT FACILITY AND PERSONAL INFORMATION

PSYCHIATRIST/LAST TREATMENT FACILITY:

DATE LAST TREATED:

STREET ADDRESS: CITY:

STATE: ZIPCODE:

PHONE: FAX:

PSYCHIATRIC DIAGNOSIS:

PSYCHIATRIC MEDICATIONS:

CURRENT PHARMACY (phone number, location):

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

In your opinion, do you believe this person is a danger to him/herself or others? (yes or no):

If you answered yes, please briefly explain:

OTHER MEDICAL INFORMATION

OTHER MEDICAL CONCERNS: Yes ☐ No ☐ If yes, other diagnosis and medication:

MEDICAL DOCTOR'S NAME:

STREET ADDRESS: CITY:

STATE: ZIP CODE: OFFICE PHONE:

Information submitted by (print name) Relationship:

Phone: Signature:

You may attach an additional page to continue to answer questions or to provide other information you thing is useful.