INMATE MEDICATION INFORMATION FORM

INMATE INFORMATION

If you believe your family member is suicidal or has an urgent medical condition that requires immediate attention, call the jail immediately at (805) 781-4600 and ask for the on-duty sergeant.

FULL LEGAL NAME OF INMATE: ______________________________

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

DOB: ______________ BOOKING #: ______________________

FAMILY CONTACT INFORMATION

FAMILY CONTACT NAME: ______________________ RELATIONSHIP ______________

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

DAYTIME PHONE: ______________________ EVENING PHONE: ______________________

Forms that do not contain your contact information may not be considered valid.

PSYCHIATRIST/TREATMENT FACILITY INFORMATION

PSYCHIATRIST: ______________________ DATE LAST TREATED: ______________

LAST TREATMENT FACILITY: ______________________________

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

PHONE: ______________________ FAX: ______________________

MEDICAL INFORMATION

DIAGNOSIS: ______________________________

DAYTIME MEDICATIONS: ______________________________

____

DOSAGE: ______________________________

NIGHTTIME MEDICATIONS: ______________________________

____

DOSAGE: ______________________________

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

____

____

IS SUICIDE A CONCERN? NO ______YES ______ IF YES, WHY? ______________________________

____

____

IF YES, IMMEDIATELY CALL (805) 781-4600 AND ASK FOR THE ON –DUTY SERGEANT

____

OTHER MEDICAL CONCERNS: ______________________________

____

____

MEDICATIONS PRESCRIBED FOR THESE CONDITIONS: ______________________________

MEDICAL DOCTOR'S NAME: ______________________ OFFICE PHONE: ______________

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

JAIL MEDICAL/MENTAL HEALTH SERVICES

FAX: (805) 781-5342 or Email: sh-inmate-medical-pdf@co.slo.ca.us

☐**PRINT** ☐**SUBMIT FORM** (Submit using *Internet Explorer)*