



---

# CHAIRMAN'S MEMORANDUM

## NO. 08-2009                      October 30, 2009

---

TO:    SHERIFFS, COMMISSIONERS OF CORRECTION, JAIL ADMINISTRATORS, AND MEDICAL DIRECTORS

RE:    REVISED CORRECTION LAW, SECTION 601(A) RELATING TO HEALTH TRANSFER INFORMATION

---

Based on the Americans with Disabilities Act, NYS Criminal Procedure Law, Corrections Law and other recent legislation, plus an increasing number of men and women in custody who suffer from chronic medical and mental health illnesses, it has become apparent that the current Health Transfer Information Form is no longer efficient in providing a comprehensive summary. In consultation with representatives from New York State's Department of Correctional Services (NYS DOCS), Department of Health, and Office of Mental Health, as well as volunteers from the county jails, a revision was completed to better improve communication between all entities involved in the health care of the New York's incarcerated population.

As a result of the cooperative efforts of all, a revised Health Transfer Information Form to satisfy the requirements of Section 601(a) of the New York State Correction Law is now available. New features of the enclosed form include clearer guidelines concerning when to complete a telephone notification to the NYS DOCS Medical Classification and Movement Analyst, plus a data set to improve the identification of inmates with both physical and/or sensory disabilities. Additionally there is revision to the Mental Health Information section which reports more concise information regarding psychiatric diagnoses.

There is also an additional HIV- Health Transfer Information Form to report laboratory results and other facts, which only needs to be completed on **confirmed** HIV/AIDS cases being transferred.

As with the older version of the form, all pages of the Health Transfer Information Form need to be completed on all patient transfers and placed in a sealed envelope, to protect patient confidentiality. The transfer procedures as to when to use this new Health Transfer Information Form and HIV- Health Transfer Information Form remain the same; the only difference is the form. As of **January 1, 2010**, please use the new form for all transfers to NYS DOCS and all other interfacility transfers.

---

New York State Commission of Correction  
80 Wolf Road, 4<sup>th</sup> Floor  
Albany, New York 12205  
(518) 485-2346

---

Thomas A. Beilein, Chairman  
  
Daniel L. Stewart, Commissioner  
Phyllis Harrison-Ross, M.D., Commissioner

The new Health Transfer Information Form (#3611SOC) can be ordered from the NYS DOCS Elmira Print Shop by requesting it either by fax at 607-734-4052 or contacting the Elmira Print Shop by telephone at 607-734-3901, ext. 2300. The price for the two page form is \$32.00 per package if ordering one to nine packages. If ordering ten or more packages, the price is reduced to \$27.20 a package. Each package will consist of seventy-five sets of the two pages that complete the Health Transfer Information Form.

Please note these forms are produced in triplicate for distribution as indicated at the bottom of page two. Sample copies of the revised forms are attached for your reference.

The one-page HIV - Health Transfer Information Form (#3114SCOC) can also be ordered through the Elmira Print Shop. The prices are \$18.00 a package for one to nine packages; if requesting ten or more packages, the cost is decreased to \$15.30 a package. Each package of the HIV - Health Transfer Information Form includes one hundred sixty forms.

For those facilities that have a low number of transferees that would require an HIV - Health Transfer Information Form, it is suggested that consideration be given to several counties splitting a package for use.

Please contact the Commission's Forensic Medical Unit at (518) 485-2463 if you have any questions.



**Thomas A. Beilein, Chairman**

---

**New York State Commission of Correction**  
80 Wolf Road, 4<sup>th</sup> Floor  
Albany, New York 12205  
(518) 485-2346

**Thomas A. Beilein, Chairman**

**Daniel L. Stewart, Commissioner**

**Phyllis Harrison-Ross, M.D., Commissioner**

Name: \_\_\_\_\_  
(Last) (First) (MI) (DOB) NYSID/DIN/Class & Movement

Medications: List or attached profiles:

NAME	DOSAGE	ROUTE	FREQUENCY

**MEDICAL SECTION COMPLETED BY:**

Print Name/Title/Facility/Phone w/extension \_\_\_\_\_ / \_\_\_\_\_ Date

**MENTAL HEALTH INFORMATION:**

1. Is the inmate currently receiving mental health services?  No  Yes. If yes, list diagnoses:

- Axis I: \_\_\_\_\_
- Axis II: \_\_\_\_\_
- Axis III: \_\_\_\_\_
- Current psychiatric symptoms: \_\_\_\_\_

2. Is the inmate on psychiatric medication(s)?  No  Yes. If yes, list medication, dose, frequency, and compliance. If injectable, indicate last date given: \_\_\_\_\_

3. Is the inmate currently in specialized housing for inmates with mental health illness?  No  Yes

4. Is the inmate assaultive?  No  Yes. If yes, provide history: \_\_\_\_\_

5. Is the inmate currently on a suicide watch?  No  Yes Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Has the inmate recently been on a suicide watch?  No  Yes Date \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_

Has the inmate made a suicide attempt during this incarceration?  No  Yes Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Has the inmate engaged in self-injurious behavior?  No  Yes Date \_\_\_\_/\_\_\_\_/\_\_\_\_

If "Yes" to any of the above, briefly describe: \_\_\_\_\_

6. Has the inmate ever been psychiatrically hospitalized?  No  Yes

7. Any psychiatric hospitalizations during this incarceration?  No  Yes  
If "Yes" to either, hospital and date (Attach discharge summary) \_\_\_\_\_

**MENTAL HEALTH SECTION COMPLETED BY:**

Print Name/Title/Facility/ Phone # w/extension \_\_\_\_\_ / \_\_\_\_\_ Date

COPIES: White (DOCS Medical); Canary (OMH Unit Chief); Pink (Sending Facility)

**HEALTH TRANSFER INFORMATION PURSUANT TO SECTION 601 (a) CORRECTION LAW**

This form is completed when the health record does not accompany the inmate and is necessary to provide continuity of care. Healthcare providers (if available) place the form in a sealed envelope marked: Confidential Health Information" indicating inmate name, sending facility, and receiving facility.

NAME \_\_\_\_\_  
 (Last) (First) (MI) DOB NYSID/DIN/Class & Movement

If any conditions listed here are present, complete the form and do not transfer patient without contacting NYS DOCS Medical Classification and Movement Analyst at (518) 457-7072 to ensure medical supply/equipment access and follow-up services are timely. Telephone notification must be made for anyone who:

- Is pregnant
- Is housed in infirmary/isolated/mental observation unit
- Physically or sensory disabled (uses wheelchair, crutches, cane, walker, prosthesis, is blind and/or deaf)
- Requires durable medical equipment such as CPAP/BiPAP, insulin pump, infusion line, trachea suction
- Has unstable medical condition (i.e. recent seizure activity, significant hypo/hyperglycemic events) or transfer will interrupt ongoing specialty care such as dialysis of chemotherapy
- Has known exposure to or active illness with transmittable disease (i.e. active TB, active MRSA, acute hepatitis A/B/C, measles, mumps, and chickenpox).
- Is currently withdrawing or detoxifying from alcohol or drugs
- Requires methadone/narcotic, injectable medications; 1:1 drugs, special order medication or dressing material

Allergies: \_\_\_\_\_

Asthma or other breathing disorder	N	Y	HIV	N	Y
Diabetes	N	Y	Hepatitis B	N	Y
Seizure Disorder	N	Y	Hepatitis C	N	Y
Developmental Disability	N	Y	Blind	N	Y
IV Drug User	N	Y	Deaf	N	Y
Speech Impairment	N	Y	Dental	N	Y
Language Barrier	N	Y	Varicella	N	Y

Other Significant Problems: \_\_\_\_\_

Lab tests (if available)	Date Done	Results
RPR/FTA/VDRL	_____	_____
GC/Chlamydia	_____	_____
Pap Smear	_____	_____
Pregnancy	_____	_____
INR/PT/PTT	_____	_____
Chest X-ray	_____	_____
Hepatitis B	_____	_____
_____	_____	_____
_____	_____	_____

**Immunization Dates & Type:**  
 Hepatitis B \_\_\_\_\_  
 Hepatitis A \_\_\_\_\_  
 Influenza \_\_\_\_\_  
 Tetanus (dT/Tdap) \_\_\_\_\_  
 Other \_\_\_\_\_

If HIV +, must also complete additional form for HIV information

**Tuberculin Testing**  
 TST: Date Read: \_\_\_\_\_  
 Result in mm of induration: \_\_\_\_\_  
 Interpretation of TST (positive or negative) \_\_\_\_\_  
 If Blood test for TB, specify test \_\_\_\_\_

TB Blood Test	Date	Result
Latent TB History (Yes/No) / Meds / Dates	_____	_____
_____	_____	_____
_____	_____	_____

Active TB Treatment (Yes/No) History / Meds  
 Dates \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Attach recent chest x-ray report if available

MRSA or Other Resistant Organism Treatment History:

\_\_\_\_\_

Additional Information (e.g. recent hospitalizations, or list any outstanding medical appointments, including name, address, phone number for provider) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

STATE OF NEW YORK - DEPARTMENT OF CORRECTIONAL SERVICES  
**HIV – HEALTH TRANSFER INFORMATION PURSUANT TO SECTION 601 (a) CORRECTIONAL LAW**

PRINT NAME	DIN	DOB
------------	-----	-----

HIV Confirmation HIV Serology/Date \_\_\_\_\_ / \_\_\_\_\_ and/or HIV VL / Date \_\_\_\_\_ / \_\_\_\_\_

ARV Therapy yes \_\_\_\_\_ no \_\_\_\_\_

Serology (Annual): RPR titer/FTA-ABS/Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Result Toxoplasmosis/ Date \_\_\_\_\_ / \_\_\_\_\_ Result CMV Titer/ Date \_\_\_\_\_ / \_\_\_\_\_

Result Pap Test/ Date \_\_\_\_\_ / \_\_\_\_\_

Hepatitis Screening Results/Date HAVIgM \_\_\_\_\_ / \_\_\_\_\_ HAVAb Total \_\_\_\_\_ / \_\_\_\_\_

HBcAb \_\_\_\_\_ / \_\_\_\_\_ HBeAb \_\_\_\_\_ / \_\_\_\_\_ HBeAg \_\_\_\_\_ / \_\_\_\_\_ HBsAb \_\_\_\_\_ / \_\_\_\_\_

HBsAg \_\_\_\_\_ / \_\_\_\_\_ HCVAb \_\_\_\_\_ / \_\_\_\_\_ HCVRNA \_\_\_\_\_ / \_\_\_\_\_

DATE							
CBC	WBC						
	Hct/Hgb						
	Platelets						
Chems	Glucose (FBS)						
	BUN						
	Creatinine						
	Albumin						
	AST/ALT						
	Cholesterol-Fast						
	HDL/LDL -Fast						
	Trig.-Fast						
CD4 count / %							
Viral Load/Log							

Resistance Assays: Genotype, Phenotype/Date \_\_\_\_\_ / \_\_\_\_\_

CXR/Date \_\_\_\_\_ / \_\_\_\_\_

Quantiferon Test Results (CD4 < 300)/Date \_\_\_\_\_ / \_\_\_\_\_

Other: Test Results/Date \_\_\_\_\_ / \_\_\_\_\_

\_\_\_\_\_ / \_\_\_\_\_

Comments \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_