I. PURPOSE. To describe the procedure for the transmittal of detailed summaries of custodial and health information for the valid transfer of inmates between DOCS and local facilities. Section 601(a) of Correction Law as amended by Chapter 227 Laws of 1981 requires this action.

II. PROCEDURE

A. Transfers from DOCS

1. Each transferred inmate shall be accompanied by Custodial Transfer Information Form 3610, a Health Transfer Information Form 3611, and, if appropriate, a Patient Referral Form 3275 and photocopied health information (see Attachments A, B, and C).

A Patient Referral Form 3275 is to be completed whenever an inmate requires follow-up by a physician. Portions of the health record may be photocopied and forwarded to the receiving facility to ensure continuity of care.

The Health Transfer Information Form, Patient Referral Form, and any photocopied health information are to be enclosed in a sealed envelope marked with the following information for custodial staff:

```
From: (Sending Facility) To: (Receiving Facility)
Inmate Name: __________ Inmate DIN _________
[ ] Known Physical or Mental Health Problems ______
[ ] Immediate Medical Attention Required _________
[ ] Medication _____________________________
CONFIDENTIAL-HEALTH INFORMATION ENCLOSED
```

2. Where an inmate has been in the care of a Satellite Unit, the Mental Hygiene Unit Chief will prepare a summary of relevant psychological information which shall also be attached either in the Health envelope or in a separate envelope marked with the same information as the Health envelope.

3. Each form shall provide information that is current as of the time of transfer.

4. Each form shall be filled out by persons who are qualified to provide the information and have been designated by the Superintendent to do so.

5. It is the responsibility of the Inmate Records Coordinator to ensure that the specified Custodial and Health Transfer Forms and, where required, the Mental Health envelope are attached to the other documents accompanying the inmate. Wherever any required forms have not been provided it shall be the responsibility of the Inmate Records Coordinator to report to his or her supervisor for appropriate action by the supervisor.

6. A copy of the Custodial Transfer Form shall be retained in the Guidance Unit Folder of the inmate, and a copy of the Health Transfer Form shall be retained in the inmate's Active Health Record.
7. It is the responsibility of the facility that has requested a transfer order for the inmate in compliance with a court order to carry out the above procedures.

8. Although not required by Section 601 (a), custodial and health information should also be provided in the same manner when inmates are transferred to the custody of criminal justice agencies other than local facilities (such as other states or the federal prison system).

B. Transfers to DOCS from Local Facilities

1. Upon receipt of the Confidential Health Information it shall be sent immediately and unopened to the Health Unit.

2. Upon receipt of the Custodial Transfer Form it shall be sent immediately to staff receiving the inmate. The form shall be filed in the inmate's Guidance Unit Folder.

3. Action that is appropriate based on the information contained in the Custodial, Health, and Mental Health Forms shall be taken.

C. Facility Procedures. Each facility shall establish written procedures to implement this directive, and the procedures shall be filed in the offices of the Superintendent of the facility.
STATE OF NEW YORK - DEPARTMENT OF CORRECTIONAL SERVICES

CUSTODIAL TRANSFER INFORMATION
PURSUANT TO SECTION 601A CORRECTION LAW

<table>
<thead>
<tr>
<th>Sending Facility</th>
<th>Date:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name (Last, first)</th>
<th>Din:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Alias (Last, first)</th>
<th>NYSID:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>In Custody Since</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mo. Day Yr.</td>
<td>Mo. Day Yr.</td>
</tr>
</tbody>
</table>

Known Physical Problems? | Yes [ ] | No [ ] |

Known Mental Health Problems? | Yes [ ] | No [ ] |

Enter a "Y" or "N" for each item:

<table>
<thead>
<tr>
<th>Immediate medical attention required</th>
<th>Potential Victim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication</td>
<td>Enemies (give names and locations if known)</td>
</tr>
<tr>
<td>Escape/Attempted escape/Hostage Taking</td>
<td>Good performance in work/program assignment</td>
</tr>
<tr>
<td>Assaultive toward staff/staffmates</td>
<td>Arson while in custody</td>
</tr>
<tr>
<td>Drugs/Weapons/Other serious contraband</td>
<td>Restrictions on outside contacts</td>
</tr>
<tr>
<td>Self-injury/Self-injury attempt</td>
<td>Other</td>
</tr>
<tr>
<td>Central Monitoring Case</td>
<td></td>
</tr>
</tbody>
</table>

Explain any item checked "Y" above to assist receiving staff to deal with inmate.

Adjustment in confinement: Good [ ] | Fair [ ] | Poor [ ]

Prepared by:

<table>
<thead>
<tr>
<th>Name:</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title:</td>
<td>Telephone No.</td>
</tr>
</tbody>
</table>

Security Review:

<table>
<thead>
<tr>
<th>Name:</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title:</td>
<td></td>
</tr>
</tbody>
</table>

cc: Guidance Folder
INSTRUCTIONS FOR FILLING OUT CUSTODIAL TRANSFER FORM

1. Enter the inmate’s name, alias, DIN, NYSID, and date of birth as given on Function 82 of the Reception/Classification System.

2. Relevant and up to date information concerning the inmate’s behavior during custody should be included. If an item on the check list is checked "Y", specific substantiating information should be provided below.

3. "Known Physical Problems" and "Known Mental Health Problems" must be checked yes or no. Because medical information is in a sealed confidential envelope, it is crucial that any medical information relevant to custodial staff (such as physical limitations, epilepsy, medication) be included on the form. The information must be up to date.

4. Check "Central Monitoring Case" if the inmate is a State C.M.C. case or if the inmate is being transferred to New York City and his original New York City Inmate Transfer Information Sheet indicated he was a City C.M.C. case. Specify if the inmate is a State C.M.C. case, was a City C.M.C. case or both.

5. If an inmate is an overt homosexual, check "Other" and specify.

6. The general evaluation of the inmate’s adjustment should be based on the following definitions:

   Good: The inmate's cooperation with the requirements of the facility is exceptional.

   Poor: The inmate has failed to cooperate with the requirements of the facility in a significant way.

   Fair: The inmate has performed acceptably. Fair is a broad category covering a wide range of inmates.

7. Information on the inmate’s behavior prior to custody that is relevant and verified should also be included.
ATTACHMENT B

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.

Health Care Staff (if available) place the form in a sealed envelope "Confidential - Health Information" indicating inmate name, sending facility and receiving facility.

The sending facility calls the receiving facility if inmate requires 24 hour nursing care and/or possible hospitalization to an acute center.

Attach Suicide Prevention Screening Guideline Form from intake, if available.

NAME ________________________ D.O.B. ________ DIN. ________ NYSID ________

A Physical Assessment has □ has not □ been completed.

HEALTH INFORMATION

<table>
<thead>
<tr>
<th>Condition</th>
<th>No</th>
<th>Yes</th>
<th>Date of Last Incidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma or Breathing Disorder</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seizure Disorder</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Syphilis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WDA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Last Drug Used</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Allergies

Dental Problems? □ No □ Yes Explain ________________________

List medications

MENTAL HEALTH INFORMATION

1. Is the inmate currently receiving mental health services? Yes □ No □

   If yes, problem: __________________________

   Name of Tx Provider: __________________________ Telephone: ( )

2. Is the inmate currently housed in a mental observation cell and/or under increased supervision for MH reasons? Yes □ No □

   Reasons: __________________________

3. Has the inmate been on suicide watch? Yes □ No □

   Last Date: __________________________

   Suicide attempt (s)? Yes □ No □

   Last Date: __________________________

   Has the inmate made suicidal statements/gestures? Yes □ No □

   Last Date: __________________________

4. History of self mutilation? Yes □ No □

   Explain: __________________________

5. Past known psychiatric hospitalization? Yes □ No □

   Hospital and date: __________________________

6. Current mental health related medications (dosage, date of last dose)? __________________________

Additional information related to current treatment should be noted, e.g., current medications, significant lab work, any information related to TB tests, such as tuberculin tests and any pending reports with lab test numbers for follow up. Any information regarding work disabilities, prostheses, hearing, visual, or blindness, previous hospitalization should also be noted. (Use reverse side of form if needed.)

__________________________
Signature

__________________________
Facility

__________________________
Phone # (with extension)

__________________________
Date

White - Envelope 3272 with inmate
Canary - Internat Facility
Inmate Information (Custodial and Health) During Transfer of Custody

Date: 12/18/00

This replaces page 5 dated 12/01/09

Attachment C

If this is a telemedicine encounter, has the inmate read the instructional sheet or been instructed on the telemedicine encounter?

Yes ☐ No ☐

Date of Service: ____________________ Referral To: ____________________

State of New York - Department of Correctional Services

Patient Referral Form

Name ____________________ Din ____________________ Dob ____________________ SS # ____________________

Vital Signs: Temp ________ Pulse ________ Resp ________ BP ________ Ht ________ Wt ________

I. Reason for Referral: (include present illness and symptoms, other specific diagnoses)

*Has inmate had any of these symptoms within the last week? ☐ Cough ☐ Fever ☐ Nightsweats
☐ Hemoptysis ☐ Severe Fatigue ☐ Weight Loss over 10lbs. in last 3 months (Explain above if symptoms noted)

II. Current Labs, X-Rays, or Diagnostic Tests related to Referral *(include latest CD4 if applicable)

*CXR Date: ____________________ Result: ____________________

III. Current Medications and/or Treatments (Name, Route, Dose and Frequency with Start and Stop Dates)

Allergies ☐ Yes ☐ Describe ____________________

IV. Significant Past Medical/Surgical History

No ________ Yes ________ Date of Last Incidence ________

Asthma or Breathing Disorder ________ Diabetes ________ Heart Disease ________ Hepatitis ________

Seizure Disorder ________ Syphilis ________

Other specific considerations (e.g., operations, disabilities):

Trtmt. for: ☐ Posit PPD ☐ Diagnosed TB

Medications: ____________________

Start Date: ___________ End Date: ___________

List Drugs Used ____________________

V. Psychiatric Diagnosis? ☐ No ☐ Yes ☐ Specific Diagnosis ____________________

Psychiatric Medications ____________________

Referring Physician's Name ____________________ (Please Print)

Signature of Health Provider Completing Form ____________________ Date ____________________

Correctional Facility ____________________ Phone ____________________ Ext. ___________

*Information required by SUNY Health Science Center for referral.
CENTRAL NEW YORK PSYCHIATRIC CENTER
TRANSFER SHEET - COUNTY JAIL DISCHARGES

Date:

Patient Name:

“C” Number:

Transfer of one inmate will be made from this institution to ______________________

County Jail, and the following records will be sent to the Sheriff and Mental Health Contact (s)
as indicated:

TO SHERIFF:

_____ Sentence Papers

_____ Discharge Summary

_____ County Jail Record

TO MENTAL HEALTH UNIT:

_____ Discharge Summary - Core History/Evaluation

_____ Nursing Discharge Plan

_____ Pharmacy Profile/Lab Work

_____ Copies to Additional Mental Health Contact

TO JAIL PHYSICIAN:

_____ Nursing Discharge Plan

_____ Lab Work

_____ Pharmacy Profile

The above records and papers were prepared on ________________________________

by ________________________________

(Name and Title)

The above inmate, records and papers were received on ________________________________

by ________________________________

(Name and Title)
<table>
<thead>
<tr>
<th>DISCHARGE SUMMARY/SERVICE PLAN (INPATIENT)</th>
<th>Patient’s Name: “C”/Id. No.:</th>
</tr>
</thead>
<tbody>
<tr>
<td>PART I - DISCHARGE SUMMARY</td>
<td></td>
</tr>
<tr>
<td>PART II - NURSING DISCHARGE</td>
<td></td>
</tr>
</tbody>
</table>

**Destination:**

**Date of Admission:**

**Date of Discharge:**

**Patient’s Name:**

**Date of Birth:**

**Unit/Ward No.:**

**DIN No.:**

**Facility Name:**

**CENTRAL NEW YORK PSYCHIATRIC CENTER**

**1. HISTORY:** Attach existing documentation (or an abstract) which includes the following information, as indicated.

- Presenting Problem(s)
- Mental/Physical Health
- Alcohol and Drug Use/Abuse
- Diagnosis
- Medications

**Attached:**

**REASON FOR ADMISSION:**

2. **ALERTS:** List risk factors including danger to self/others, CPL status, physical health conditions/needs, allergies (See Part II Nursing Discharge), etc.

**PRECAUTIONS:**

**LEGAL ISSUES:**

**SECURITY ISSUES:**

3. **COURSE OF TREATMENT:** Describe the course of treatment and the status of all goals which were to be met before discharge. Include the most effective treatments.

**COURSE OF TREATMENT:**

**FAMILY INVOLVEMENT:**

**SPECIAL TREATMENT PROCEDURES:**
4. RECOMMENDATIONS ON DISCHARGE:

THERAPY/COUNSELING:

EDUCATIONAL/VOCATIONAL:

MEDICATIONS:

5. DIAGNOSIS: Enter a "P" in front of the principal diagnosis.

Axis I:

Axis II:

Axis III:

Axis IV: Psychosocial Stressors:

a. Stressor(s):


c. Duration: 1. | Predominately Acute Event 2. | Predominately Enduring Circumstances

Axis V: Global Assessment of Functioning: (Enter two digit scores from 01-90)

a. Current GAF Score _____ Past GAF (Highest) Score _____

6. CONDITION ON DISCHARGE: Describe current functioning.

DISCHARGE MENTAL STATUS:

Staff Signature:

Title:

Physician’s Signature:

Title:

Dictated:

Transcribed:
Part II: NURSING DISCHARGE SUMMARY
Central New York Psychiatric Center

1. SPECIAL ALERTS/PRECAUTIONS -- (include allergies, self-abuse, non-compliance, homicidal/suicidal ideation, potential/actual EPS, escape risk, sexual acting out, etc.). If none, state "None".

2. CURRENT BEHAVIOR:

3. LAB WORK -- List most recent ones; include dates and attach copies of results to Nursing Discharge Summary:

4. CONSULTATIONS -- List consultations which may require follow-up and attach copies of recommendations. If none, state "None":

5. TESTS / IMMUNIZATIONS while at CNYPC. (List any necessary follow-up under #6 - Physical Health.):

<table>
<thead>
<tr>
<th>TEST</th>
<th>DATE</th>
<th>RESULTS</th>
<th>TEST</th>
<th>DATE</th>
<th>RESULTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mantoux</td>
<td></td>
<td></td>
<td>Pap Smear</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diphtheria/Tetanus</td>
<td>N/A</td>
<td></td>
<td>Mammogram</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal Vaccine</td>
<td>N/A</td>
<td></td>
<td>Chest X-Ray</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flu Vaccine</td>
<td>N/A</td>
<td></td>
<td>EKG</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B Vaccine</td>
<td>N/A</td>
<td></td>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Exam</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
NURSING DISCHARGE SUMMARY

6. PHYSICAL HEALTH:
   Activity Tolerance ____________________ Diet ____________________
   Sleep Pattern ________________________  Weight ____________________
   Personal Hygiene:  Self-Care: □ Yes □ No  Needs Monitoring: □ Yes □ No

   The following physical health problems and recommendations are noted. If none,
   state “None”.

7. DISCHARGE MEDICATIONS -- (Include Dosage, Time, Route, Form. If applicable,
   date next injection due):

8. PATIENT EDUCATION/HEALTH TEACHING PROVIDED -- (Include medication, diet,
   HIV, general health, stressors, etc.):

9. SUMMARIZE PATIENT’S RESPONSE TO EDUCATION/HEALTH TEACHING, including
   need for reinforcement of education/health teaching.

10. OTHER NURSING CONSIDERATIONS -- If none, state “None”.

11. I reviewed these discharge instructions and had an opportunity to ask questions.

   PATIENT SIGNATURE ____________________  Date ____________

   Discharge R.N. Signature ____________________  Date ____________

   Receiving RN Signature ____________________  Date ____________