HEALTH SERVICES KITE

This form must be used to request non-emergency healthcare services, except in facilities where kiosks or sign-up sheets are used.

<table>
<thead>
<tr>
<th>PLEASE PRINT</th>
<th>SUBMISSION OF HEALTH SERVICES REQUEST MAY RESULT IN A CO-PAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>LAST NAME</td>
<td>FIRST NAME</td>
</tr>
<tr>
<td>DOC NUMBER</td>
<td>FACILITY</td>
</tr>
<tr>
<td>JOB/PROGRAM</td>
<td>JOB/PROGRAM HOURS</td>
</tr>
</tbody>
</table>

If you feel you have an actual medical emergency, alert the staff and do not use this form.

TYPE OF REQUEST (check only one box per form)

- MEDICAL
- DENTAL
- MENTAL HEALTH
- MEDICATION REFILL – List medication(s) with prescription number(s) or place sticker below
- OPTOMETRY
- OTHER: __________________________

REASON FOR REQUEST (list problem or medications needing refill)

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_____________________________ PATIENT SIGNATURE ________________________________

HEALTH SERVICES RESPONSE/ENCOUNTER

This form must be filed if any information is entered below except for: simple prescription refills, finance, non-medical work/bunk change, religious diets, shoes, classification, complaints about staff, non-health services issues

- Schedule within _____ days/weeks/months
- Next available sick call
- No visit required

RESPONDER signature and stamp (all copies) DATE and TIME

Distribution: WHITE/YELLOW – Responder, PINK – Patient keeps
Distribution upon completion: WHITE – Health Record, YELLOW – Return to Patient with Response

State law and/or federal regulations prohibit disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.