Department of Corrections
WASHINGTON STATE

SELF-WELLNESS CHECK
AUTOEVALUACIÓN DE BIENESTAR

Instructions / *Instrucciones*:
To be completed by the segregated individual and Shift Commander **immediately** upon an after-hours arrival to the Secured Housing Unit (SHU) in a stand-alone minimum facility and **daily** on weekends and holidays.

*El individuo en segregación y el Comandante de Turno deben llenar este formulario **inmediatamente** al llegar a deshoras a la unidad de vivienda asegurada (SHU) in una instalación autónoma de seguridad mínima y **diariamente** los fines de semana y días feriados.*

Additional information may be written on back, if needed.
Se puede agregar información adicional al dorso, si es necesario.

NAME (Last, First) / *NOMBRE (Apellido, Nombre):*	DOC NUMBER / *NUMERO DOC:*	FACILITY / *INSTALACION:*
RECEIVED FROM / *RECIBIDO DE:*	DATE / *FECHA:*	TIME / *HORA:*

PATIENT TO COMPLETE THIS SECTION
EL PACIENTE DEBERA LENAR ESTA SECCION

Check all your current problems /
Marque todos sus problemas actuales:

- ☐ Diabetes / *Diabetes*
- ☐ Seizures / *Convulsiones*
- ☐ Rash / *Sarpullido*
- ☐ Chest pain / *Dolor de pecho*
- ☐ Asthma – Are you short of breath?
  Asma – ¿Le falta el aire? ☐ No ☐ Yes/*Sí*
- ☐ Nausea and vomiting / *Náuseas y vómitos*
- ☐ Open wounds or sores/*Heridas o lesiones abiertas*
- ☐ Thoughts of suicide or self-harm
  Pensamientos de suicidio o de hacerse daño
- ☐ Pregnant (Females Only) / *Embarazada (Sólo mujeres)*
- ☐ Pain – Explain below
  Dolor – Explique abajo

_____

_____

- ☐ Medication allergy (list below)
  Alergias a los medicamentos (apúntelos abajo)

_____

_____

- ☐ Dietary issues (list below)
  Problemas de dieta (apúntelos abajo)

_____

_____

- ☐ I want to see a mental health provider
  Quiero ver a un profesional de salud mental

SHIFT COMMANDER OBSERVATION

Check all that apply:

- ☐ Not Conscious*****
- ☐ Difficulty speaking or forming words*****
  ***Call 911 and render first-responder aid**
- ☐ Confused or disoriented
- ☐ Shaking/sweating/nausea/vomiting/diarrhea
- ☐ Extremely abnormal behavior and/or conduct
- ☐ Behavioral changes after admission
- ☐ Threats of self-harm
- ☐ Body or bone deformities
- ☐ Injuries/bruising
- ☐ Difficulties with walking or standing
- ☐ Wheelchair
- ☐ Crutches
- ☐ Refusing consecutive meals – How many? _____

After completing the form, if there are any health concerns indicated by the individual or if the shift commander has any concerns about the individual's health, call the MOD immediately to notify him/her that the individual is in the SHU and to receive medical care instructions.

Circle those medications which have been identified by the MOD to be returned to individual.

☐ No meds to be returned

_____ _____
MOD NAME TIME

By signing this form, I am acknowledging that I have observed and spoken to this individual as part of the daily wellness check requirement.

SHIFT COMMANDER SIGNATURE

I am taking the following medications (list both OTC and prescription, continue on back if needed) /
Tomo los medicamentos de la lista que sigue (con y sin receta, apuntados al dorso si es necesario):

_____

_____

☐ I have no medical, dental, or mental health problems / *No tengo problemas médicos, dentales o de salud mental*

_____
PATIENT SIGNATURE / *FIRMA DEL PACIENTE*

Send completed form to Medical for filing in the Health Record

SELF-WELLNESS CHECK / *AUTOEVALUACIÓN DE BIENESTAR*

NAME (Last, First): *NOMBRE: (Apellido, Nombre):*	DOC NUMBER:	DATE:

PATIENT ADDITIONAL INFORMATION ***INFORMACIÓN ADICIONAL DEL PACIENTE***

SHIFT COMMANDER ADDITIONAL INFORMATION

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.
Las leyes estatales y/o los reglamentos federales prohíben la revelación de esta información sin el consentimiento específico por escrito de quien se trata, o según la ley.