PARTIAL CONFINEMENT
HEALTH SERVICES SCREENING

Name: ___________________________ DOC number: ________ Date: ______________

Date of birth: ____________________ Facility/unit: _______________________

**Health Services:** Gather information from all providers currently engaged with the patient to determine appropriateness, potential accommodations, and Health Services related needs for partial confinement and return to the screener.

### GENERAL HEALTH SERVICES NEED

Check all applicable boxes below:

- [ ] High medical/mental health. Coordinate with social work employees to identify community treatment options and continuity of care.
- [ ] Home and community services referral necessary to ensure continued care in the community.
- [ ] Patient would like to complete medical services prior to release to partial confinement. Eligible to transfer on or after ____________.
- [ ] In process for receiving dentures, prosthetics, etc. Eligible to transfer on or after ____________.
  (models/measurements/impressions completed and are waiting for arrival of the item for fitting)

### LIMITATIONS OF MOBILITY, SENSORY DISABILITY, ADA ACCOMMODATION

- [ ] Yes  [ ] No  The individual has limitations of mobility, sensory disability, or ADA accommodation?
- [ ] Assistive device necessary for mobility. Ensure housing is accessible: __________________________
- [ ] Has accommodation need in the community: __________________________

### DEVELOPMENTAL DISABILITY

- [ ] May be eligible for services through Developmental Disability Administration and/or Division of Vocational Rehabilitation. Work with facility social work employees for referral and additional information.
- [ ] May need additional support understanding conditions of Reentry Center placement and/or electronic home monitoring.

### DECISION

- [ ] Appropriate for partial confinement at this time.

**Not appropriate for partial confinement at this time.** Check all applicable boxes below:

- [ ] Involuntary medications and/or current Close Observation Area placement.
- [ ] Current emergent medical/dental care need.
- [ ] Undergoing medical/mental health/substance use treatment that needs to be completed prior to partial confinement.
- [ ] Other (specify reason): __________________________

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Reviewed by name ___________________________ Title ___________________________

Signature ___________________________ Date ___________________________

The contents of this document may be eligible for public disclosure. Social Security Numbers are considered confidential information and will be redacted in the event of such a request. This form is governed by Executive Order 16-01, RCW 42.56, and RCW 40.14.

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