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): ________________

________________ ________________

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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