STATE OF NEW YORK DEPARTMENT OF CORRECTIONAL SERVICES **DIRECTIVE**	TITLE **Inmate Information (Custodial and Health) During Transfer of Custody**	NO. 4019	
SUPERSEDES Dir. #4019 dtd. 04/15/94	DISTRIBUTION A	PAGE 1 OF 6 PAGES	DATE 3/2/98
REFERENCES (includes but are not limited to): Correction Law, Sec. 601(a)	APPROVING AUTHORITY		

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.

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REPLACES PAGE 3 DATED 3/2/98 REVISION DATE 12/1/99

Attachment A

FORM 3610 (4/98)

STATE OF NEW YORK - DEPARTMENT OF CORRECTIONAL SERVICES

CUSTODIAL TRANSFER INFORMATION

PURSUANT TO SECTION 601A CORRECTION LAW

Sending Facility _____ Date: _____

Name (Last, first) _____ Din: _____

Alias (Last, first) _____ NYSID: _____

Date of Birth _____ (Mo. Day Yr.) In Custody Since _____ (Mo. Day Yr.)

Known Physical Problems? yes ☐ No ☐

Known Mental Health Problems? yes ☐ No ☐

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

	Y	N		Y	N
Immediate medical attention required			Potential Victim		
Medication			Enemies (give names and locations (if known)		
Escape/Attempted escape/Hostage Taking			Good performance in work/prog. assignment		
Assaultive toward staff/inmates			Arson while in custody		
Drugs/Weapons/Other serious contraband			Restrictions on outside contacts		
Self-injury/Self-injury attempt			Other		
Central Monitoring Case					

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

_____

_____

_____

_____

Adjustment in confinement: Good ☐ Fair ☐ Poor ☐

Prepared by:

Name: _____ Signature _____

Title: _____ Telephone No. _____

Security Review:

Name: _____ Signature _____

Title: _____

cc: Guidance Folder

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REPLACES PAGE 4 DATED 3/2/88 REVISION DATE 12/1/99

Attachment A

(page 2)

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.

STATE OF NEW YORK
DEPARTMENT OF CORRECTIONAL SERVICES

REVISION NOTICE

TITLE: Inmate Information (Custodial and Health) During Transfer of Custody

NO. 4019

NOTE: THIS REPLACES PAGES 5 & 6 DATED 12/01/99
Page 6 - Form 3275 (Attachment C) was revised 09/98

APPROVING AUTHORITY

REVISION DATE 12/18/00

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 _____ (Last) _____ (First) D.O.B. _____ DIN. _____ NYSID _____

HEALTH INFORMATION

A Physical Assessment has ☐ has not ☐ been completed.

	No	Yes	Date of Last Incidence
Asthma or Breathing Disorder			
Diabetes			
Heart Disease			
Hepatitis			
Seizure Disorder			
Syphilis			
Hypertension			
IVDA			

Last Drug Used _____

Allergies _____

	No	Yes	Date
CXR			
Tetanus			
Pap smear			
HIV Tested			
Result			
PPD Date			mm. Anergic
Treated			
VDRL Date		Neg	Pos
Treated			
G. C. Smear Date		Neg	Pos
Treated			

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? No ____ Yes ____ 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 tx - such as sputum tests including pending reports with lab test numbers for followup. Any information regarding work disabilities, prostheses, hearing, 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 - Intransit Facility Pink - Inmate Ambulatory Health Care Record Misc. Div.

3811 (02/98)

NO. 4019 INMATE INFORMATION (CUSTODIAL AND HEALTH) DURING TRANSFER OF CUSTODY

DATE 12/18/00 THIS REPLACES PAGE 6 DATED 12/01/99

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: _____ Referred 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 CD_4 if applicable)

*CXR Date: _____ Result: _____

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

Allergies No _____ 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			

	No	Yes	Date
Tetanus			
HIV Tested			
Result			

Latest PPD Date _____ Neg ☐ Pos ☐ _____ mm

Prior PPD Date _____ Neg ☐ Pos ☐ _____ mm

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

Trtmnt. 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.***

Distribution: Original - Hospital/consultant or Clinic
Copy - Attach to consultation report/clinic info and place in Consultation Divider

FORM 3275 (09/98)

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:
____ via mailing address
____ via transport officers

_____ Discharge Summary - Core History/Evaluation
Nursing Discharge Plan
Pharmacy Profile/Lab Work

_____ Copies to Additional Mental Health Contact

TO JAIL PHYSICIAN:
____ via mailing address
____ via transport officers

_____ 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)

DISCHARGE SUMMARY/SERVICE PLAN (INPATIENT) PART I - DISCHARGE SUMMARY PART II - NURSING DISCHARGE Destination: Date of Admission: Date of Discharge:	Patient's Name: "C"/Id. No.: 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: CORE HISTORY/EVALUATIONS
NURSING DISCHARGE PLAN
PHARMACY MEDICATION PROFILE

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:

Patient's Name:
"C"/Id. No.:

Discharge Summary continued

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): b. Severity: 1. | | None 2. | | Mild 3. | | Moderate 4. | | Severe 5. | | Extreme 6. | | Catastrophic 0. | | Inadequate Info./No Change 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:

CNY-161B (Rev 3/99)

Part II: NURSING DISCHARGE SUMMARY

Central New York Psychiatric Center

(PLEASE PRINT)

Name:

"C" No.

Ward:

DOB:

DIN#:

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.):**

TEST	DATE	RESULTS	TEST	DATE	RESULTS
Mantoux			Pap Smear		
Diphtheria/Tetanus		N/A	Mammogram		
Pneumococcal Vaccine		N/A	Chest X-Ray		
Flu Vaccine		N/A	EKG		
Hepatitis B Vaccine		N/A	Other		
Physical Exam		N/A			

NURSING DISCHARGE SUMMARY PAGE 2

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