MIAMI COUNTY SHERIFF'S OFFICE

209 S. PEARL STREET PAOLA, KS 6607

913-294-3232

FAX: ADMINISTRATION & RECORDS 913-294-9118 · COMMUNICATIONS 913-285-6606 · JAIL 913-294-9547

FRANK W. KELLY
SHERIFF

MATTHEW P. KELLY
UNDERSHERIFF

Medical Information Form

The purpose of this form is to provide a method for family members/significant others to communicate with medical staff at the **Miami County Sheriff's Jail (MISO)** about their loved one's mental health history. **Completing this form is voluntary; it is not required. Further, all questions do not have to be answered.**

This information will be kept in medical records as a hard copy (paper copy) only. For accuracy it should be re-submitted each time a person is incarcerated. Medical providers are prohibited from giving medical information to family members/significant others without authorization from the person in jail. However, treatment providers may receive information from family members/significant others.

Important – ALL medical and mental health treatment decisions, as well as prescription medication decisions for the inmate, shall be made by the hired and/or contracted medical staff of the Miami County Sheriff after reviewing and/or verifying information on this form.

The completed form may be mailed, faxed, or hand delivered to the MISO. Fax to Medical Staff at 913-294-9547; mail or hand deliver in a sealed envelope to Medical Staff, Miami County Sheriff's Office 209 S. Pearl St., Paola, KS 66071.

Incarcerated Individuals Information

Date: _____

First Name: _____ M.I. _____ Last Name: _____

Date of Birth: _____ Home Phone: _____Cell Phone: _____

Address: _____

Emergency Contact Information

Primary Contact:

First Name: _____ Last Name: _____

Primary Phone: _____ Work/Alternate Phone: _____

Relationship to the Individual: _____

Secondary Contact:

First Name: _____ Last Name: _____

Primary Phone: _____ Work/Alternate Phone: _____

Relationship to the Individual: _____

Mental Health Provider/Treatment Facility and Personal Information

Name of Mental Health Provider: _____ Date Last Treated: _____

Name of Last Treatment Facility: _____

Address of Facility: _____

Phone: _____ Fax: _____

Diagnosis: _____

_____

Medications: _____

_____

Current Pharmacy (phone number, location): _____

Prior adverse medication effects (i.e., side effects, allergies, poor effect): _____

_____

In your opinion, do you believe this person is a danger to him/herself or others? ☐ No ☐ Yes

If yes, please explain: _____

_____

In your opinion, does this person have a history of being aggressive or violent to others? ☐ No ☐ Yes

If yes, please explain: _____

_____

Other Medical Information

Other medical concerns? ☐ No ☐ Yes

If yes, other diagnosis and medication: _____

_____

Medical Doctor's Name: _____ Phone Number: _____

Address: _____

Name of Person Completing Form: _____

Relationship to Individual: _____ Cell Phone: _____

Signature: _____ Date: _____