State of Maine
Board of Corrections

County Jail Medical Transfer Form

Transfer From: [Correctional Facility] **To:** [Correctional Facility] **Date**: [Date of Transfer]

Patient Name:	ID #:	DOB:

Transfer/Sending Information:

Is patient currently being treated for a medical, mental health, or dental condition (including chronic illness)? ☐ Yes ☐ No If yes, explain: _____

Is patient currently prescribed any medication?

☐ Yes ☐ No If yes, list medication: _____

Date of patient's last chronic care clinic visit: _____ ☐ N/A

Date of patient's last TB Screen: _____ Result: _____

If past TB Screen was positive: Last CXR: _____ Result: _____

Patient's current activity limitations (check all that may apply):

☐ Bottom bunk ☐ Crutches ☐ Wheelchair ☐ Blind ☐ Other: _____

Patient's drug allergies: _____ ☐ N/A

Patient's pending consultations/outside appointments: _____ ☐ N/A

Name/Signature: _____/_____ Date: _____

Receiving Information:

Patient's appearance (i.e. sweating, tremors, anxious, etc.): ☐ Normal ☐ Abnormal

If abnormal, explain/describe: _____

Patient's difficulty of ease of movement (i.e. body deformities, galt, etc.): ☐ Yes ☐ No

If yes, explain/describe: _____

Is there evidence of abuse or trauma? ☐ Yes ☐ No

If yes, explain/describe: _____

Disposition information

☐ General population

☐ General population with the following referral:

☐ Medical ☐ Mental Health ☐ Dental Referral date: _____

☐ Urgent/Emergent treatment needed: _____

Name/Signature: _____/_____ Date: _____