

**AMENDMENT #3
DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES
CONTINUITY OF CARE**

DATE OF RELEASE: _____
TYPE OF RELEASE: _____

Patient Identification:

NAME: _____ AKA _____ DPSCS # _____

BIRTHDATE _____ SOCIAL SECURITY NUMBER _____

LAST KNOWN ADDRESS _____

Major Health Problems (Include medical and known psychiatric problems) (Do not use abbreviations)

ALLERGIES: _____ PROBLEMS _____

Aftercare Plan (If Applicable) Include any Appointments Made for the Patient:

Medications/Treatment Orders Given to the Inmate at Release

Medication/Treatment Order	Dose/Order	Administration Method	# Given

The following Lab tests and/or X-rays done during the last year were abnormal. We advise you to seek medical follow-up with your family doctor or nearby hospital (clinic).

Lab and/or X-ray	Date	Results

Most recent PPD Results (X-ray results if previous positive PPD): Date: _____ Result: _____

Most recent Physical Examination was done: Date: _____

Medical/Nurse Provider's Signature

Institution

Date

Medical personnel have reviewed the original of this form with me and I understand that it will be given to me upon my release with my discharge medications:

Patient's Signature

Form and Medications (if applicable) taken to Release by:

Printed Name Signature Title Date