

SICK CALL REQUEST

Check One: () Dental () Medical () Mental Health

Name _____ Date of Birth _____

Booking Number/CID# _____ Housing _____

Why do you want to be seen? _____

When did you last attend sick call? _____ / _____ / _____ Your next court date? _____ / _____ / _____

Inmate Signature _____ Date _____

*** Do not write below dotted line- for Staff use only ***

Pick up date/time/initials: _____ Routine: Y / N

Seen at RNSC date/time/initials: _____

Scheduled to be treated by: ☐ Medical ☐ Dental ☐ Mental Health ☐ Vision on _____ / _____ / _____

Inmates may be charged a three dollar (\$3.00) fee for inmate initiated non-emergency medical, dental, or eye care services per 4011.2 PC. No inmate will be denied access to medical care or treatment due to lack of funds in their inmate account.

Assess three dollar fee _____ / _____ / _____
YES / NO (circle one) Physician's/Nurse's signature and body number _____ Date _____

White: Medical Records

Yellow: Jail Staff

Pink: Client Copy

[ENTERED _____]