WEBER COUNTY CORRECTIONAL FACILITY
INTAKE SCREENING
(To Be Filled Out by WCCF Officers Only)

Name:_____ Age:_____ Sex:_____ Date_____ Time_____

1. Y N Have you been involved in an accident or fight during the last 24 hours? If so list injuries.

2. Y N Do you expect to have withdrawals while at the jail? If so, from what and when did you last use?
_____

3. Y N Are you suicidal?

4. Y N Have you attempted suicide in the past?
If Yes, When?_____ How?_____ Why?_____

5. Y N Are you presently being treated by a psychiatrist or mental health counselor?
If Yes, Who?_____ Why?_____

6. Y N Are you currently taking any psychiatric medications?
If Yes, What Medications?_____Diagnosis_____

7. Y N Do you have any illnesses, or other conditions requiring medication?
If Yes, List Condition_____ Dr._____ Medication?_____
_____

8. Y N Have you had any recent illnesses or injuries, or are you pregnant? If Yes, What/Expected delivery date?__
_____

9. Y N Do you have any contagious or communicable diseases?
If Yes, What?_____ Dr._____ Treatment?_____

10. Y N Do you have any allergies or special dietary needs? If Yes, List_____
_____

11. Y N Is there anyone you feel you should be separated from? If Yes, Name(s)_____
Reason_____

12. Y N Have you had a TB test/chest x-ray to screen for TB in the last year? Where and when was it done?_____
_____Have you ever had a +PPD/TB test or received BCG? If yes, when and where
_____

13. Y N Do you have medical insurance? If Yes, Name of Provider _____

14. Y N If available, do you want a Hepatitis A / B vaccine?

15. Y N Is there any other information that we should know that is important for your health, safety, and well-being while you are in the jail? If yes, list_____

Behavior (please circle) Hostile Agitated Confused Disoriented Withdrawn Unremarkable Cooperative

16. Y N WCCF Officer: Do you feel this person needs to be checked by medical ? ☐ Yes ☐ No
Y N Did inmate get placed on an 8 hour watch in booking? Reason_____
_____

WCCF Officer Signature_____printed name_____ Arresting agency_____

Medical staff screening signature_____printed name_____Date/Time_____

Disposition by medical: Medical housing NSC DSC Mental health Suicide watch Mental health watch
Date scheduled for: _____ _____ _____ _____ _____