ADMINISTRATIVE POLICIES AND PROCEDURES State of Tennessee Department of Correction	Index #: 113.60	Page 1 of 1
	Effective Date: August 9, 2019	
	Distribution: A	
	Supersedes: N/A	
Approved by: Tony Parker		
Subject: DENTAL SERVICES ADMINISTRATION		

POLICY CHANGE NOTICE 19-54

INSTRUCTIONS:

Please change Section III. to read as follows:

"APPLICATION: Wardens, Associate Wardens/Superintendents, Associate Wardens of Treatment/Deputy Superintendents, Health Administrators, Dentists, dental care staff, medical contractors, privately managed institutions, and inmates".

Please strikethrough CR-3431 on page 7 add the attached page 8 to the policy and renumber policy pages accordingly.

TENNESSEE DEPARTMENT OF CORRECTION
INSTITUTIONAL HEALTH SERVICES REFERRAL

_____
INSTITUTION

☐ MEDICAL ☐ DENTAL
☐ BEHAVIORAL HEALTH

INMATE: _____ NUMBER: _____
Last First Middle

PRESENTING PROBLEMS: _____

_____

_____

_____

_____

_____

_____

REFERRED BY: _____ _____ _____
Signature/Title Date Time

SEND REFERRAL FORM TO INSTITUTIONAL HEALTH COORDINATOR

☐ Behavioral Health
☐ Medical ☐ Dental

RECEIVED BY: _____ _____ _____
Signature/Professional Title Date Time

REFERRAL DISPOSITION (Course of Action): _____

_____

_____

_____

_____

_____

_____

_____ DATE: _____ TIME: _____

_____
Signature/Professional Title

TENNESSEE DEPARTMENT OF CORRECTION
HEALTH SERVICES
REFUSAL OF MEDICAL SERVICES

INSTITUTION: _____

Date _____ 20 _____ Time _____ AM/PM

This is to certify that I _____ (Inmate's Name) _____, _____ (TDOC Number) _____

have been advised that I have been scheduled for the following medical services and/or have been advised to have the following evaluations, treatment, or surgical/other procedures:

_____

_____

_____

I am refusing the above listed medical services against the advice of the attending physician and/or the Health Services staff. I acknowledge that I have been informed of the risks involved by my refusal and hereby release the State of Tennessee, Department of Correction, and their employees from all responsibility for any ill effects which may be experienced as a result of this refusal. I also acknowledge this medical service may not be made readily available to me in the future unless an attending physician certifies my medical problem as a medical emergency.

Signed: _____ _____ _____
(Inmate) (TDOC number) (Date)

Witness: _____ _____ _____
(Signature) (Title) (Date)

The above information has been read and explained to,

_____ _____ but has refused to sign
(Inmate's Name) (TDOC number)
the form.

Witness: _____ _____ _____
(Signature) (Title) (Date)

Witness: _____ _____ _____
(Signature) (Title) (Date)