

KANSAS DEPARTMENT OF CORRECTIONS
MEDICAL CLASSIFICATION REPORT

APPENDIX E

PART I

228 OMIS Class

P U L H E X
 M-

Comments:

PART II

230 OMIS Smoker Non-Smoker

OMIS Anticipated re-evaluation date: _____

231 OMIS Living unit assignments:

- Bottom bunk only
- Medically unable to walk 100 yards
- No stair climbing
- Wheel chair required for activities of daily living
- Must live in a facility that is handicapped accessible
- Other:

233 OMIS Anticipated date of PULHEX re-evaluation: _____

232 OMIS Medical Issues:

- Leg orthopedic/arthritis problems, poor circulation, low back problems
- Heart disease, breathing problems, high blood pressure
- Stomach condition/diabetes
- Arm orthopedic/arthritis problems, upper back/neck problems, recurrent
- Prone to seizure, dizziness and/or fainting episodes
- Hard of hearing and/or persistent ringing in ears
- Prone to heat strokes, skin disease aggravated by prolonged exposure to sun or heat
- Foot or leg problems and unable to tolerate wearing safety shoes
- Other Medical Issues:

OMIS 229 Work Detail NOT requiring:

- Restrict assignment requiring prolonged crawling, stooping, running, walking, or standing
- Restrict assignment requiring prolonged strenuous physical activity for periods in excess of ____ hours ____ minutes
- Restrict assignment requiring handling/lifting heavy material in excess of ____ pounds
- Restrict assignment requiring overhead work for a period of ____ hours ____ minutes
- Restrict assignment where sudden loss of consciousness would be dangerous to self or others i.e.: working on scaffolding, driving a vehicle, or working near moving machinery.
- Restrict assignment requiring continued exposure to loud noise.
- Restrict assignment requiring exposure to high environmental temperature for a period in excess of ____ hours ____ minutes
- Restrict assignment which requires safety shoes/medically required to wear special shoes
- Restrict from aggressive sport activities which may cause adverse effects to inmate's medical condition

Inmate Name (Last, Middle, First)	DOC	DOB	Race/Sex	Facility

MEDICAL CLASSIFICATION TOOL

FOR

PULHE-"X"

<p>M-1: Good to excellent physical condition; physical capable of handling all work and housing.</p>
<p>M-2: Average to good physical condition; can exert sustained effort over long periods, is physically capable of most work assignments; disability, if any will not be jeopardized by such general assignment. THIS INMATE IS NOT TO TRANSFER UNTIL CLEARANCE IS OBTAINED FROM THE REGIONAL MEDICAL DIRECTOR.</p>
<p>M-3: Fair to average physical condition; can exert sustained effort for only moderate periods; limitations may affect some aspect of work/housing assignment consideration. THIS INMATE IS NOT TO TRANSFER UNTIL CLEARANCE IS OBTAINED FROM THE REGIONAL MEDICAL DIRECTOR.</p>
<p>M-4: Poor to fair physical condition; limited physical capacity of stamina; can exert sustained effort for short periods only; limitations may require special consideration. THIS INMATE IS NOT TO TRANSFER UNTIL CLEARANCE IS OBTAINED FROM THE REGIONAL MEDICAL DIRECTOR.</p>
<p>M-5: Poor physical condition; severely physical capacity or stamina; required physician authorization for any work assignment and may require special housing considerations. THIS INMATE IS NOT TO TRANSFER UNTIL CLEARANCE IS OBTAINED FROM THE REGIONAL MEDICAL DIRECTOR.</p>
<p>M-6: THIS INMATE IS NOT TO TRANSFER UNTIL THE MENTAL HEALTH COORDINATOR IS CONTACTED REGARDING APPROPRIATE HOUSING OF THE INMATE.</p>

11/1/2010

Medical Classification Key Sheet

P	U	L	H	E
GENERAL PHYSICAL	UPPER EXTREMITY	LOWER EXTREMITY	HEARING	EYES
1. No significant medical condition.	1. No impairment.	1. No impairment.	1. No impairment.	1. No impairment.
2. Minimal to moderate medical condition: Good control.	2. Slight impairment; does not limit working with hands.	2. Slight impairment; does not limit walking, standing, and climbing.	2. Slight impairment; no hearing aid needed	2. Vision correctable to 20/20. Not worse than 20/100.
3-4. Moderate medical condition—requires close medical support.	3-4. Moderate impairment; DOES limit working with hands, arms, and shoulders.	3-4. Moderate impairment; DOES limit walking, standing, and climbing.	3-4. Hearing aid indicated.	3-4. Limited vision; use of glasses NECESSARY.
5. Significant medical condition needing close medical support or special consideration.	5. Loss/Paralysis of limb; decreased upper body strength and range of motion.	5. Loss/Paralysis of limb(s); decreased lower body strength and range of motion.	5. Deaf in one or both ears to the extent that special consideration is needed.	5. Loss of vision in one or both eyes to the extent special consideration is needed.
6. Pregnant				

PULHEX KEY

- P:** Physical capability, stamina
U: Upper extremities
L: Lower extremities
H: Hearing
E: Eyes (vision)
- 1=Strongest 2-3= Intermediate 4=Weakest 5=Terminal 6=Pregnant
 1=Strongest 2-3=Intermediate 4=Weakest 5=No Arms
 1=Strongest 2-3=Intermediate 4=Weakest 5=No Legs
 1=Normal; hears whisper voice 2, 3, 4=Intermediate 5=Deaf
 1=20/20 both eyes 2, 3, 4=Intermediate 5=Total bilateral blindness

ADA Questionnaire ADA Compliance Reviewed ↻

1. Has a significant hearing defect?	<input type="radio"/> No <input type="radio"/> Yes	7. Has mobility issues?	<input type="radio"/> No <input type="radio"/> Yes
2. Is deaf?	<input type="radio"/> No <input type="radio"/> Yes	a) Walking assistance required?	<input type="radio"/> No <input type="radio"/> Yes
3. Has a significant visual deficit?	<input type="radio"/> No <input type="radio"/> Yes	b) Wheelchair?	<input type="radio"/> No <input type="radio"/> Yes
4. Is blind?	<input type="radio"/> No <input type="radio"/> Yes	c) No stairs?	<input type="radio"/> No <input type="radio"/> Yes
5. Has medical issue resulting in disability?	<input type="radio"/> No <input type="radio"/> Yes	d) Bathing/dressing assistance required?	<input type="radio"/> No <input type="radio"/> Yes
6. Is Frail?	<input type="radio"/> No <input type="radio"/> Yes	e) Requires an aid worker?	<input type="radio"/> No <input type="radio"/> Yes
a) Due to medical issue?	<input type="radio"/> No <input type="radio"/> Yes	f) Prosthetic device required?	<input type="radio"/> No <input type="radio"/> Yes
b) Due to age?	<input type="radio"/> No <input type="radio"/> Yes	8. Is on O2?	<input type="radio"/> No <input type="radio"/> Yes
		9. Uses CPAP?	<input type="radio"/> No <input type="radio"/> Yes

1. Has a significant hearing defect?
2. Is deaf?
3. Has a significant visual deficit?
4. Is blind?
5. Has medical issue resulting in disability?
6. Is Frail?
a) Due to medical issue?
b) Due to age?
7. Has mobility issues?
a) Walking assistance required?
b) Wheelchair?
c) No stairs?
d) Bathing/dressing assistance required?
e) Requires an aid worker?
f) Prosthetic device required?
8. Is on O2?
9. Uses CPAP?
Documented By
Documented Date
Documented Time

Activities of Daily Living ↻

Feeding:	<input type="radio"/> Self	<input type="radio"/> Supervision	<input type="radio"/> Assistant (1)	<input type="radio"/> Assistant (2)
Ambulation	<input type="radio"/> Self	<input type="radio"/> Supervision	<input type="radio"/> Assistant (1)	<input type="radio"/> Assistant (2)
Hygiene:	<input type="radio"/> Self	<input type="radio"/> Supervision	<input type="radio"/> Assistant (1)	<input type="radio"/> Assistant (2)
Toileting:	<input type="radio"/> Self	<input type="radio"/> Supervision	<input type="radio"/> Assistant (1)	<input type="radio"/> Assistant (2)
Transfers:	<input type="radio"/> Self	<input type="radio"/> Supervision	<input type="radio"/> Assistant (1)	<input type="radio"/> Assistant (2)

ADA Questionnaire ADA Compliance Reviewed

- | | | | |
|---|--|--|--|
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| 3. Has a significant visual deficit? | <input type="radio"/> No <input type="radio"/> Yes | b) Wheelchair? | <input type="radio"/> No <input type="radio"/> Yes |
| 4. Is blind? | <input type="radio"/> No <input type="radio"/> Yes | c) No stairs? | <input type="radio"/> No <input type="radio"/> Yes |
| 5. Has medical issue resulting in disability? | <input type="radio"/> No <input type="radio"/> Yes | d) Bathing/dressing assistance required? | <input type="radio"/> No <input type="radio"/> Yes |
| 6. Is Frail? | <input type="radio"/> No <input type="radio"/> Yes | e) Requires an aid worker? | <input type="radio"/> No <input type="radio"/> Yes |
| a) Due to medical issue? | <input type="radio"/> No <input type="radio"/> Yes | f) Prosthetic device required? | <input type="radio"/> No <input type="radio"/> Yes |
| b) Due to age? | <input type="radio"/> No <input type="radio"/> Yes | 8. Is on O2? | <input type="radio"/> No <input type="radio"/> Yes |
| | | 9. Uses CPAP? | <input type="radio"/> No <input type="radio"/> Yes |

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8. Is on O2?			
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	Documented By	Documented Date	Documented Time

Juvenile Medical Needs/Score

- M-1 Able to handle any housing, school, or program assignment
 - No treatment needs
 - No physical limitation or acute medical needs
 - Not enrolled in chronic care clinic
- M-2 Chronic condition that may need to be considered for work/programs/or school
 - Stable HTN, diabetes, seizure disorder, asthma, or other chronic illness
 - Limitation may affect some aspect of youth's work/programs/or school
- M-3 Significant Clinical Needs
 - Placement at a facility that can accommodate close medical observation

Juvenile Restrictions/Special Needs

- | | | |
|--|---|--|
| <input type="checkbox"/> Mobility
Unable to walk up or down stairs
Unable to walk more than <input type="text"/> yards without resistance
Wheel Chair required
Specify other assistive device
No lifting > <input type="text"/> pounds | <input type="checkbox"/> Activity
Unable to participate in sports
Sports Exception: <input type="text"/>
Other Restriction
Specify Other Restriction: <input type="text"/> | <input type="checkbox"/> Condition Alert
<input type="checkbox"/> Diabetic-may be prone to hypoglycemic reactions
<input type="checkbox"/> Asthma-Needs Rescue Inhaler
<input type="checkbox"/> Seizure Prone
<input type="checkbox"/> Must have Epi-pen readily available
<input type="checkbox"/> Severe Allergy Reaction To: <input type="text"/>
<input type="checkbox"/> Other: <input type="text"/> |
| <input type="checkbox"/> Transfer Coordination
Must coordinate transfer with receiving site | <input type="checkbox"/> Perceptual
Hearing impaired
Visually impaired/requires assistance | |

Comments/Specify Needs/ or Accommodations:

Activities of Daily Living

- | | | | | |
|-------------|----------------------------|-----------------------------------|-------------------------------------|-------------------------------------|
| Feeding: | <input type="radio"/> Self | <input type="radio"/> Supervision | <input type="radio"/> Assistant (1) | <input type="radio"/> Assistant (2) |
| Ambulation: | <input type="radio"/> Self | <input type="radio"/> Supervision | <input type="radio"/> Assistant (1) | <input type="radio"/> Assistant (2) |
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| Transfers: | <input type="radio"/> Self | <input type="radio"/> Supervision | <input type="radio"/> Assistant (1) | <input type="radio"/> Assistant (2) |