Case Nos. 19-35017 and 19-35019

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

ADREE EDMO,
Plaintiff-Appellee,
v.
IDAHO DEPARTMENT OF CORRECTIONS, ET AL.,
Defendants-Appellants.

On Appeal from Orders of the United States District Court
For the District of Idaho
(No. 1:17-cv-00151-BLW)

EXCERPTS OF RECORD
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Dated: March 6, 2019

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Medication Administration Record

Documentation Codes	Staff Signature	Date	Initials	Staff Signature	Date	Initials
	A. Benton, LPN	3-2014		D. Jensen, LPN	3-2014	K. Pilote, RN, ADON
	A. Beshears, RN	3-2014		~~J. King, LPN~~	3-2014	J. Prudhomme, LPN
D/C - Discontinued	~~C. Hutchburn, LPN~~	3-2014		S. Kitto, RN	3-2014	D. Rainier, LPN
R - Refused	C. Brenenstahl, dialysis tech	3-2014		K. Larsen, LPN	3-2014	C. Read, LPN
	G. Brewer, RN	3-2014		T. Lee, RN	3-2014	E. Reed, LPN
A - Absent	L. Brown, LPN	3-2014		D. Luna, LPN	3-2014	J. Revard, CMS
	~~M. Bryant, RN~~	3-2014		S. Mallet, LPN	3-2014	G. Rodriguez, LPN
O - Other	~~G. Capshaw, RN~~	3-2014		~~R. Malone, LPN~~	3-2014	~~J. Savell, LPN~~
	T. Castello, HST	3-2014		C. Marria, LPN	3-2014	M. Scifres, HST
	S. Deeds, LPN	3-2014		T. Mccall, LPN	3-2014	~~R. Spurlock, LPN~~
	J. Drake, LPN	3-2014		K. Murray, RN	3-2014	~~A. Thurber, LPN~~
	V. Ferro, LPN	3-2014		H. Nader, RN	3-2014	F. Valenzuela, RN
	~~L. Green, RN~~	3-2014		~~C. Newby, CMS~~	3-2014	~~Vasquez, S, C N A~~
	L. Hill, Pharm Tech	3-2014		A. Nisby, LPN	3-2014	I. Whitworth, RN
	D. Hoxey, CMS	3-2014		S. Patterson, LPN	3-2014	~~C. Wilson, LPN~~
	A. Huddleston, C N A	3-2014		S. Perus, LPN	3-2014	W. Wingert, RN, DON
	A. Ing, LPN	3-2014		H. Pierce, LPN	3-2014	~~C. Young, LPN~~
	Julie Savell, LPN	3-2014			3-2014	WILCOX CNA
		3-2014			3-2014	
Date/Time		3-2014		NOTES	3-2014	

ER 2033

MEDICATION ADMINISTRATION RECORD

Facility: **Month:**

Init.	Drug - Dose - Mode - Interval	HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	ASA 81 mg Take 1 PO QDay x30 Prescriber Whinney Order Date 2-19-14 Start Date 2-20-14 Stop Date 3-20-14									Inm Sign: DATE: 2-22-14 # Disp: 15 Staff: DL											DL						K	K	K	K			
	Oscal-D 500 1250mg Take 1 PO Qday Prescriber Whinney Order Date 2-19-14 Start Date 2-20-14 Stop Date 3-20-14									Inm Sign: DATE: 2-22-14 # Disp: 5 Staff: DL											DL						K	K	K	K			
	Zolpidem 10 mg Take 3 PO Qday x30 Prescriber Whinney Order Date 2-19-14 Start Date 2-20-14 Stop Date 3-20-14																				DL		DL				K	K	K	K			
	Aldactone 50 mg Take 1 PO Bid x30 Prescriber Whinney Order Date 2-19-14 Start Date 2-20-14 Stop Date 3-20-14									Inm Sign: DATE: 2-22-14 # Disp: 8 Staff: DL											DL						K	Ø	Ø	Ø			
	Estrace 2mg 10 Qday x30 Prescriber Whinney Order Date 2-19 Start Date 2-20 Stop Date 3-20									Inm Sign: DATE: 2-22-14 # Disp: 21 Staff: DL											DL						K	K	K	K			
	Proscar 5mg PO Qday x30 Prescriber Whinney Order Date 2-19 Start Date 2-20 Stop Date 3-20-14									Inm Sign: DATE: 2-22-14 # Disp: 7 Staff: DL											DL						K	K	K	K			

Diagnosis: 94691 L6340 Edmo, Mason A-20

Allergies: NKDA DOB/Inmate #: [redacted] Location: Name:

#3150 REV 4/10

ER 2034

Medication Administration Record

Documentation Codes	Staff Signature	Date	Initials
	A. Benton, LPN		
	A. Beshears, RN		
D/C - Discontinued Order	~~C. Brenenstahl, dialysis tech~~		
R - Refused	G. Brewer, RN		
	L. Brown, LPN		
A - Absent	~~M. Bryant, RN~~		
	G. Capshaw, RN		
O - Other	T. Castello, HST		
	S. Deeds, LPN		
	J. Drake, LPN		
	V. Ferro, LPN		
	~~L. Green, RN~~		
	L. Hill, Pharm Tech		
	D. Hoxey, CMS		
	A. Huddleston, C N A		
	A. Ing, LPN		

Staff Signature	Date	Initials
D. Jensen, LPN		
J. King, LPN		
~~S. Kitto, RN~~		
K. Larsen, LPN		
T. Lee, RN		
D. Luna, LPN		
S. Mallet, LPN		
~~R. Malone, LPN~~		
C. Marria, LPN		
T. Mccall, LPN		
K. Murray, RN		
H. Nader, RN		
C. Newby, CMS		
S. Patterson, LPN		
S. Perus, LPN		
H. Pierce, LPN		

Staff Signature	Date	Initials
K. Pilote, RN, ADON		
J. Prudhomme, LPN		
D. Rainier, LPN		
~~C. Read, LPN~~		
E. Reed, LPN		
J. Revard, CMS		
G. Rodriguez, LPN		
~~M. Scifres, HST~~		
~~R. Spurlock, LPN~~		
A. Thurber, LPN		
F. Valenzuela, RN		
Vasquez, S, C N A		
L. Whitworth, RN		
~~C. Wilson, LPN~~		
W. Wingert, RN, DON		
~~C. Young, LPN~~		

Date/Time	NOTES

ER 2035

Pg:314
Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID **Month:** April 2014

Init.	Drug - Dose - Mode - Interval	HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	SPIRONOLACTONE 50 MG TABS ~ALDACTONE~ 3/19 #60 TAKE 1 TAB BY MOUTH TWICE DAILY FOR 210 DAYS >> MAY CAUSE DIZZINESS << Prescriber WHINNERY,CATHERINE Rx#30247089 Order Date 03/07/14 Start Date 03-07-14 Stop Date 10/03/14	K O P				Init Sign DME DATE: 4/4/14 # Disp: 60 Staff: DB												1 2						DC'ed Per Whinnery									
	Change Zoloft to 150mg. 90 QAM X120D Prescriber Olsen Order Date 4-9-14 Start Date 4-10-14 Stop Date 8-8-14	Am											V 40																				
	Prescriber Order Date Start Date Stop Date																																
	Prescriber Order Date Start Date Stop Date																																
	escriber Order Date Start Date Stop Date																																
	Prescriber Order Date Start Date Stop Date																																

Diagnosis: No Known Drug Allergy
Allergies:

[redacted] 94691 DOB/Inmate #:

6340- MAIN() Location: 9/2

EDMO, MASON Name:

PharmaCorr

#3150 REV 4/10

ER 2036

Medication Administration Record

Documentation Codes	Staff Signature	Initials	Signature	Date	Staff Signature	Initials	Signature	Date	Staff Signature	Initials	Signature	Date
	A. Benton, LPN	[signature]	[signature]	[redacted]	D. Jensen, LPN	DJ	[signature]	4-2014	K. Pilote, RN, ADON	[signature]	[signature]	4-2014
	~~A. Eshears, ...~~	[signature]	[signature]	4-2014	~~J. King, LPN~~	[signature]	[signature] [redacted]	4-2014	~~J. Prudhomme, LPN~~	[signature]	[signature]	4-2014
D/C - Discontinued Order	~~G. Blackburn, LPN~~		[signature]	4-2014	S. Kitto, RN	[signature]	[signature]	4-2014	D. Rainier, LPN	[signature]	[signature] LPN	4-2014
	C. Brenenstahl, dialysis tech	CB	[signature]	4-2014	K. Larsen, LPN	[signature]	[signature]	4-2014	C. Read, LPN	[signature]	[signature]	4-2014
R - Refused	G. Brewer, RN	GB	[signature]	4-2014	T. Lee, RN	[signature]	[signature]	4-2014	E. Reed, LPN	[signature]	[signature]	4-2014
A - Absent	L. Brown, LPN	[signature]	[signature] LPN	4-2014	D. Luna, LPN	DL	[signature]	4-2014	J. Revard, CMS	[signature]	[signature]	4-2014
	~~M. Bryant, RN~~			4-2014	~~S. Maller, LPN~~	[signature]	[signature]	4-2014	G. Rodriguez, LPN	[signature]	[signature]	4-2014
O - Other	G. Capshaw, RN	[signature]	[signature]	4-2014	R. Malone, LPN	[signature]	[signature]	4-2014	J. Savell, LPN	[signature]	[signature]	4-2014
	T. Castello, HST	[signature]	[signature]	4-2014	C. Marria, LPN	[signature]	[signature]	4-2014	M. Scifres, HST	[signature]	[signature]	4-2014
	~~S. Deeds, LPN~~	SD	[signature]	4-2014	~~T. Mccall, LPN~~	[signature]	[signature]	4-2014	~~A. Thurber, LPN~~	[signature]	[signature]	4-2014
	D. Dickinson, RN	DD	[signature]	4-2014	K. Murray, RN	[signature]	[signature]	4-2014	F. Valenzuela, RN	[signature]	[signature]	4-2014
	J. Drake, LPN	JD	[signature]	4-2014	H. Nader, RN	[signature]	[signature]	4-2014	Vasquez, S, C N A	[signature]	[signature]	4-2014
	V. Ferro, LPN	VF	[signature]	4-2014	~~C. Newby, CMS~~			4-2014	L. Whitworth, RN	[signature]	[signature]	4-2014
	L. Green, RN	LG	[signature]	4-2014	A. Nisby, LPN	[signature]	[signature]	4-2014	C. Wilcox C N A	[signature]	[signature]	4-2014
	L. Hill, Pharm Tech	[signature]	[signature]	4-2014	S. Patterson, LPN	[signature]	[signature]	4-2014	~~C. Wilson, LPN~~			4-2014
	D. Hoxey, CMS	[signature]	[signature]	4-2014	S. Perus, LPN	SP	[signature]	4-2014	W. Wingert, RN, DON	[signature]	[signature]	4-2014
	A. Huddleston, C N A	AH	[signature]	4-2014	H. Pierce, LPN	[signature]	[signature]	4-2014	C. Young, LPN	[signature]	[signature]	4-2014
	A. Ing, LPN	[signature]	[signature]	4-2014	C Schmidt, LPN	[signature]	[signature]	4-2014				4-2014
				4-2014	Kttyatt [signature]	[signature]	[signature]	4-2014				4-2014
				4-2014				4-2014				4-2014

Date/Time	NOTES

Pg:3/3
Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID **Month:** April 2014

Init.	Drug - Dose - Mode - Interval	HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	ASPIRIN EC 81 MG TBEC ~ECOTRIN~ 3/19 #30 TAKE 1 TAB BY MOUTH EVERY DAY FOR 210 DAYS >> DO NOT CRUSH << Prescriber WHINNERY,CATHERINE Rx#30247059 Order Date 03/07/14 Start Date 03-07-14 Stop Date 10/03/14	K O P					Inm Sign: DATE: 4.11.14 # Disp: 30 Staff:				^30																							
	CALCIUM CARB 1250MG/VIT D 1250 MG TABS ~OSCAL-D 500~ 3/19 #60 TAKE 1 TAB BY MOUTH EVERY DAY FOR 210 DAYS Prescriber WHINNERY,CATHERINE Rx#30247065 Order Date 03/07/14 Start Date 03-07-14 Stop Date 10/03/14	K O P					Inm Sign: DATE: 4.11.14 # Disp: 30 Staff:				30																							
	ESTRADIOL 1 MG TABS ~ESTRACE~ #120 3/19 TAKE 3 TABS BY MOUTH EVERY DAY FOR 90 DAYS **APPROVED** Prescriber WHINNERY,CATHERINE Rx#30248222 Order Date 03/07/14 Start Date 03-07-14 Stop Date 06/05/14	K O P					Inm Sign: DATE: # Disp: Staff:				^90																						^	
	FINASTERIDE 5 MG TABS ~PROSCAR~ 3/19 #60 TAKE 1 TAB BY MOUTH EVERY DAY FOR 90 DAYS **APPROVED** >>WOMEN OF CHILD BEARING AGE SHOULD NOT HANDLE THIS DRUG<< Prescriber WHINNERY,CATHERINE Rx#30248216 Order Date 03/07/14 Start Date 03-07-14 Stop Date 06/05/14	K O P					5 Start Inm Sign: DATE new # Disp: order 30 Staff													Inm Sign: DATE: # Disp: Staff:												
	SERTRALINE HCL 100 MG TABS ~ZOLOFT~ TAKE 1 TAB BY MOUTH EACH MORNING FOR 120 DAYS >> MAY CAUSE DROWSINESS << Prescriber SEYS,JANE,NP Rx#30263442 Order Date 03/10/14 Start Date 03-10-14 Stop Date 07/08/14	AM					30							new order 4-9-14																			
	EDMO, MASON 94691 FINASTERIDE 5 MG TABS (PROSCAR) Rx: 30408361 O/D: 04/05/14 YOUNG,MURRAY D/C: 07/05/14 TAKE 1 TAB DAILY FOR 90 DAYS (NOTE START DATE) >>WOMEN OF CHILD BEARING AGE SHOULD NOT HANDLE THIS DRUG<< 4.5.14 6340- MAIN	K O P								4/4 #90										Inm Sign: 30 DATE: 4-24-14 # Disp: 30 Staff:												

Diagnosis: No Known Drug Allergy

Allergies:

[redacted] 94691 DOB/Inmate #:

6340- MAIN() Location: 1/2

EDMO, MASON Name:

PharmaCorr

#3150 REV 4/10

ER 2038

Medication Administration Record

Documentation Codes	Staff Signature	Date	Initials	Staff Signature	Date	Initials
	A. Benton, LPN		D. Jensen, LPN		K. Pilote, RN, ADON	
	~~A. Feshears, RN~~		J. King, LPN		J. Prudhomme, LPN	
D/C - Discontinued	~~G. Hathaway, LPN~~		S. Kitto, RN		D. Rainier, LPN	
	C. Brenenstahl, dialysis tech		K. Larsen, LPN		C. Read, LPN	
R - Refused	G. Brewer, RN		T. Lee, RN		~~E. Reed, LPN~~	
A - Absent	L. Brown, LPN		D. Luna, LPN		J. Revard, CMS	
	~~M. Bryant, RN~~		S. Mallet, LPN		G. Rodriguez, LPN	
O - Other	G. Capshaw, RN		R. Malone, LPN		J. Savell, LPN	
	T. Castello, HST		C. Marria, LPN		M. Scifres, HST	
	~~S. Deeds, LPN~~		T. Mccall, LPN		A. Thurber, LPN	
	D. Dickinson, RN		K. Murray, RN		F. Valenzuela, RN	
	J. Drake, LPN		H. Nader, RN		Vasquez, S, C N A	
	V. Ferro, LPN		~~C. Newby, CMS~~		L. Whitworth, RN	
	L. Green, RN		A. Nisby, LPN		C. Wilcox C N A	
	L. Hill, Pharm Tech		S. Patterson, LPN		~~C. Wilson, LPN~~	
	D. Hoxey, CMS		S. Perus, LPN		W. Wingert, RN, DON	
	A. Huddleston, C N A		H. Pierce, LPN		C. Young, LPN	
	A. Ing, LPN		C Schmidt, LPN			

Date/Time	NOTES

ER 2039

Medication Administration Record

Documentation Codes	Staff Signature	Date	Initials	Staff Signature	Date	Initials
	A. Benton, LPN		D. Jensen, LPN		K. Pilote, RN, ADON	
	A. Beshears, RN		J. King, LPN		J. Prudhomme, LPN	
D/C - Discontinued Order	~~C. Blackburn, LPN~~		S. Kitto, RN		D. Rainier, LPN	
	C. Brenenstahl, dialysis tech		K. Larsen, LPN		C. Read, LPN	
R - Refused	G. Brewer, RN		T. Lee, RN		E. Reed, LPN	
A - Absent	L. Brown, LPN		D. Luna, LPN		J. Revard, CMS	
	~~M. Brya...~~		S. Mallet, LPN		G. Rodriguez, LPN	
O - Other	G. Capshaw, RN		R. Malone, LPN		J. Savell, LPN	
	T. Castello, HST		C. Marria, LPN		M. Scifres, HST	
	~~S. Deeds, LPN~~		~~T. Mccall, LPN~~		~~A. Thurber, LPN~~	
	D. Dickinson, RN		K. Murray, RN		F. Valenzuela, RN	
	J. Drake, LPN		H. Nader, RN		Vasquez, S, C N A	
	V. Ferro, LPN		~~C. Newby, CMS~~		L. Whitworth, RN	
	L. Green, RN		A. Nisby, LPN		C. Wilcox C N A	
	L. Hill, Pharm Tech		S. Patterson, LPN		~~C. Wilson, LPN~~	
	D. Hoxey, CMS		S. Perus, LPN		W. Wingert, RN, DON	
	A. Huddleston, C N A		H. Pierce, LPN		C. Young, LPN	
	A. Ing, LPN		C Sammidt, LPN			
			K Hyatt LPN			

Date/Time	NOTES
4/4/14	Request for pill 0900 - DL

ER 2040

Pg:312
Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID **Month:** June 2014

Int.	Drug - Dose - Mode - Interval	HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	ASPIRIN EC 81 MG TBEC ~ECOTRIN ~ I 5/16 #30 TAKE 1 TAB BY MOUTH EVERY DAY FOR 210 DAYS >> DO NOT CRUSH << Prescriber WHINNERY,CATHERINE Rx#30247059 Order Date 03/07/14 Start Date 3/7/14 Stop Date 10/03/14	AM O P																															
	CALCIUM CARB 1250MG/VIT D 1250 MG TABS ~OSCAL-D 500~ I 5/6 #30 TAKE 1 TAB BY MOUTH EVERY DAY FOR 210 DAYS Prescriber WHINNERY,CATHERINE Rx#30247065 Order Date 03/07/14 Start Date 3/7/14 Stop Date 10/03/14	AM O P																															
	ESTRADIOL 1 MG TABS ~ESTRACE~ I 5/2 #90 TAKE 3 TABS BY MOUTH EVERY DAY FOR 90 DAYS **APPROVED** Prescriber WHINNERY,CATHERINE Rx#30248222 Order Date 03/07/14 Start Date 3/7/14 Stop Date 06/05/14	K O P			A 7		S T O P							See new order																			
	FINASTERIDE 5 MG TABS ~PROSCAR~ I 5/19 #30 TAKE 1 TAB DAILY FOR 90 DAYS (NOTE START DATE) >>WOMEN OF CHIL BEARING AGE SHOULD NOT HANDLE THIS DRUG<< Prescriber YOUNG,MURRAY Rx#30408361 Order Date 04/05/14 Start Date 4/18/14 Stop Date 07/05/14	K O P			N P									See new order																			
	SERTRALINE HCL 50 MG TABS ~ZOLOFT~ TAKE 3 TABS (150MG) BY MOUTH EACH MORNING FOR 120 DAYS >> MAY CAUSE DROWSINESS << Prescriber ELIASON,SCOTT PSY Rx#30497180 Order Date 04/10/14 Start Date 4/10/14 Stop Date 08/08/14	AM									V 90																						
	Estradiol 3mg PO QD x 90 days Prescriber Povlson Order Date 6/5/14 Start Date 6/9/14 Stop Date 9/8/14	AM O P											90 V																				

Diagnosis: No Known Drug Allergy

Allergies:

94691 DOB/Inmate #:

6340- MAIN() Location: B-37

EDMO, MASON Name:

PharmaCorr

#3150 REV 4/10

ER 2041

Medication Administration Record

Documentation Codes	Staff Signature	Date	Initials	Staff Signature	Date	Initials	Staff Signature	Date	Initials
	A. Benton, LPN	6-2014		D. Jensen, LPN	6-2014		D. Rainier, LPN	6-2014	
	A. Beshears, RN	6-2014		J. King, LPN	6-2014		C. Read, LPN	6-2014	
D/C - Discontinued	~~C. Blackburn, LPN~~	6-2014		S. Kitto, RN	6-2014		E. Reed, LPN	6-2014	
	C. Brenenstahl, dialysis tech	6-2014		K. Larsen, LPN	6-2014		J. Revard, CMS	6-2014	
R - Refused	G. Brewer, RN	6-2014		T. Lee, RN	6-2014		~~R. Robinson, RN~~	6-2014	
	L. Brown, LPN	6-2014		D. Luna, LPN	6-2014		G. Rodriguez, LPN	6-2014	
A - Absent	~~M. Bryant, RN~~	6-2014		~~S. Mallet, LPN~~	6-2014		J. Savell, LPN	6-2014	
	G. Capshaw, RN	6-2014		R. Malone, LPN	6-2014		L. Schindele, C N A	6-2014	
O - Other	T. Castello, HST	6-2014		C. Marria, LPN	6-2014		~~C. Schmidt, LPN~~	6-2014	
	~~S. Deeds, LPN~~	6-2014		T. Mccall, LPN	6-2014		~~P. Taylor, RN~~	6-2014	
	~~J. Drake, LPN~~	6-2014		K. Murray, RN	6-2014		A. Thurber, LPN	6-2014	
	V. Ferro, LPN	6-2014		A. Nisby, LPN	6-2014		F. Valenzuela, RN	6-2014	
	L. Green, RN	6-2014		M. Palocsay, RN	6-2014		S. Vasquez C N A	6-2014	
	L. Hill, Pharm Tech	6-2014		S. Patterson, LPN	6-2014		~~L. Whitworth, RN~~	6-2014	
	A. Huddleston, C N A	6-2014		S. Perus, LPN	6-2014		C. Wilcox C N A	6-2014	
	K. Hyatt, LPN	6-2014		H. Pierce, LPN	6-2014		C. Wilson, LPN	6-2014	
	A. Ing, LPN	6-2014		~~K. Pilote, RN, ADON~~	6-2014		W. Wingert, RN, DON	6-2014	
	T Case LPN	6-2014		J. Prudhomme, LPN	6-2014		C. Young, LPN	6-2014	
	T. Hall LPN	6-2014			6-2014			6-2014	

Date/Time	A. Moser, CNA	AM		NOTES
6-3-14		AM		Sent a Referal To Renew Estradol To Cronic Care

ER 2042

MEDICATION ADMINISTRATION RECORD

Facility: M 6340 **Month:** June 2014

Init.	Drug - Dose - Mode - Interval	HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	Finasteride 5mg PO QD x 90days	AM											30 V										[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
		D																															
	Prescriber pulson Order Date 6/5/14 Start Date 6/9/14 Stop Date 9/8/14	P													#30 9/12/14 6/[illegible]																			
	Prescriber Order Date Start Date Stop Date																																
	Prescriber Order Date Start Date Stop Date																																
	Prescriber Order Date Start Date Stop Date																																
	Prescriber Order Date Start Date Stop Date																																
	Prescriber Order Date Start Date Stop Date																																

Diagnosis:

Allergies: NKDA

[redacted] 94691
DOB/Inmate #:

6340
Location:

Edmo, Mason
Name:

#3150 REV 4/10

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID **Month:** May 2014

Drug - Dose - Mode - Interval	HR
ASPIRIN EC 81 MG TBEC ~ECOTRIN~ I30 4/11 TAKE 1 TAB BY MOUTH EVERY DAY FOR 210 DAYS >> DO NOT CRUSH << Prescriber WHINNERY,CATHERINE Rx#30247059 Order Date 03/07/14 Start Date 3/7/14 Stop Date 10/03/14	K O P
CALCIUM CARB 1250MG/VIT D 1250 MG TABS ~OSCAL-D 500~ I30 4/11 TAKE 1 TAB BY MOUTH EVERY DAY FOR 210 DAYS Prescriber WHINNERY,CATHERINE Rx#30247065 Order Date 03/07/14 Start Date 3/7/14 Stop Date 10/03/14	K O P
ESTRADIOL 1 MG TABS ~ESTRACE~ 4/11 I90 TAKE 3 TABS BY MOUTH EVERY DAY FOR 90 DAYS **APPROVED** Prescriber WHINNERY,CATHERINE Rx#30248222 Order Date 03/07/14 Start Date 3/7/14 Stop Date 06/05/14	K O P
FINASTERIDE 5 MG TABS ~PROSCAR~ 4/24 I30 TAKE 1 TAB DAILY FOR 90 DAYS (NOTE START DATE) >>WOMEN OF CHILD BEARING AGE SHOULD NOT HANDLE THIS DRUG<< Prescriber YOUNG,MURRAY Rx#30408361 Order Date 04/05/14 Start Date 4/5/14 Stop Date 07/05/14	K O P
SERTRALINE HCL 50 MG TABS ~ZOLOFT~ V90 4/11 TAKE 3 TABS (150MG) BY MOUTH EACH MORNING FOR 120 DAYS >> MAY CAUSE DROWSINESS << Prescriber ELIASON,SCOTT PSY Rx#30497180 Order Date 04/10/14 Start Date 4/10/14 Stop Date 08/08/14	AM
Prescriber Order Date Start Date Stop Date	

Inm Sign: / DATE: / # Disp: / Staff:

Diagnosis:
No Known Drug Allergy
Allergies:

[redacted] 94691 | 6340- | MAIN() | EDMO, MASON
DOB/Inmate #: | Location: | Name:

PharmaCorr

#3150 REV 4/10

Medication Administration Record

Documentation Codes	Staff Signature	Initials
	A. Benton, LPN	
	~~A. Beshears, RN~~	
D/C - Discontinued Order	~~G. Blackburn, LPN~~	
	C. Brenenstahl, dialysis tech	
R - Refused	G. Brewer, RN	
	L. Brown, LPN	
A - Absent	~~M. Bryant, RN~~	
	G. Capshaw, RN	
O - Other	T. Castello, HST	
	~~S. Deeds, LPN~~	
	~~D. Dickinson, RN~~	
	J. Drake, LPN	
	V. Ferro, LPN	
	L. Green, RN	
	L. Hill, Pharm Tech	
	A. Huddleston, C N A	
	~~K. Hyatt, LPN~~	
	~~A. Ing, LPN~~	

Lisa Schindele, C.N.A.

Date	Initials	Staff Signature
	D. Jensen, LPN	
	J. King, LPN	
	~~S. Kitto, RN~~	
	K. Larsen, LPN	
	T. Lee, RN	
	~~D. Luna, LPN~~	
	~~S. Mallet, LPN~~	
	R. Malone, LPN	
	C. Marria, LPN	
	~~T. Mccall, LPN~~	
	P. McDonald, LPN	
	K. Murray, RN	
	H. Nader, RN	
	~~C. Newby, CMS~~	
	A. Nisby, LPN	
	M. Palocsay, RN	
	S. Patterson, LPN	
	S. Perus, LPN	
	H. Pierce, LPN	

Date	Initials	Staff Signature
	~~K. Pilote, RN, ADON~~	
	J. Prudhomme, LPN	
	D. Rainier, LPN	
	~~C. Read, LPN~~	
	E. Reed, LPN	
	J. Revard, CMS	
	R. Robinson, RN	
	G. Rodriguez, LPN	
	J. Savell, LPN	
	~~C. Schmidt, LPN~~	
	P. Taylor, RN	
	A. Thurber, LPN	
	E. Valenzuela, RN	
	Vasquez, S, C N A	
	L. Whitworth, RN	
	C. Wilcox C N A	
	~~C. Wilson, LPN~~	
	W. Wingert, RN, DON	
	C. Young, LPN	

Date/Time		NOTES
5/18/14	PM	Absent for pill pass -DL
25 /14	AM	(A) from pill call AM LPN

ER 2045

Pg:314
Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID **Month:** July 2014

Drug - Dose - Mode - Interval	Administration (days 1–31)
ASPIRIN EC 81 MG TBEC ~ECOTRIN ~ TAKE 1 TAB BY MOUTH EVERY DAY FOR 210 DAYS >> DO NOT CRUSH << Prescriber WHINNERY,CATHERINE Rx#30247059 Order Date 03/07/14 Start Date 3.8 Stop Date 10/03/14	K.O.P. 7-2-14 #30 Inm Sign: [signature] DATE: ✓ # Disp: Staff: New order
CALCIUM CARB 1250MG/VIT D 1250 MG TABS ~OSCAL-D 500~ TAKE 1 TAB BY MOUTH EVERY DAY FOR 210 DAYS Prescriber WHINNERY,CATHERINE Rx#30247065 Order Date 03/07/14 Start Date 3.8 Stop Date 10/03/14	K.O.P. 7.2 #30 Inm Sign: [signature] DATE: # Disp: Staff: New order
ESTRADIOL 1 MG TABS ~ESTRACE~ TAKE 3 TABS (3MG) BY MOUTH DAILY FOR 90 DAYS **APPROVED** Prescriber POULSON,WILLIAM NP Rx#30915124 Order Date 06/10/14 Start Date 6.11 Stop Date 09/08/14	K.O.P. 7.2 #90 Inm Sign: [signature] DATE: 7-30-14 # Disp: 90 Staff: [initials] 7.1.14 90# 90 V
FINASTERIDE 5 MG TABS ~PROSCAR~ TAKE 1 TAB BY MOUTH DAILY FOR 90 DAYS **APPROVED** >>WOMEN OF CHILD BEARING AGE SHOULD NOT HANDLE THIS DRUG<< Prescriber POULSON,WILLIAM NP Rx#30915127 Order Date 06/10/14 Start Date 6.11 Stop Date 09/08/14	K.O.P. 7.2 #15 Inm Sign: [signature] DATE: 7/8/14 # Disp: #30 Staff: DC 7-3-14 per Whinnery
SERTRALINE HCL 50 MG TABS ~ZOLOFT~ TAKE 3 TABS (150MG) BY MOUTH EACH MORNING FOR 120 DAYS >> MAY CAUSE DROWSINESS << Prescriber ELIASON,SCOTT PSY Rx#30497180 Order Date 04/10/14 Start Date 4.11 Stop Date 08/08/14	RCVD for 29X7 90
Estradiol 3mg po x 90 days Start 8/2/14 Prescriber Whinnery Order Date 7/3 Start Date 8/2 Stop Date 11/2	NOTE START DATE

[redacted]

Diagnosis: No Known Drug Allergy Allergies:	94691 DOB/Inmate #:	6340- MAIN() Location: B37	EDMO, MASON Name:

PharmaCorr

#3150 REV 4/10

ER 2046

Medication Administration Record

Documentation Codes	Staff Signature	Date	Initials	Staff Signature	Date	Initials
	A. Benton, LPN	7-2014	K. Hyatt, LPN		J. Prudhomme, LPN	
	~~A. Beshears, RN~~	7-2014	A. Ing, ~~LPN~~ RN		~~D. Rainier, LPN~~	
D/C - Discontinued Order	~~G. Blackburn, LPN~~	7-2014	D. Jensen, LPN		C. Read, LPN	7-2014
	C. Brenenstahl, dialysis tech	7-2014	~~S. Kelly, PhT~~		E. Reed, LPN	7-2014
R - Refused	G. Brewer, RN	7-2014	J. King, LPN		J. Revard, CMS	
	L. Brown, LPN	7-2014	S. Kitto, RN		~~R. Robinson, RN~~	7-2014
A - Absent	G. Capshaw, RN	7-2014	K. Larsen, LPN		G. Rodriguez, LPN	7-2014
	L. Carlson, RN, DON	7-2014	T. Lee, RN		J. Savell, LPN	7-2014
O - Other	T. Case, LPN	7-2014	D. Luna, LPN		L. Schindele, C N A	7-2014
	~~P. Cleveland, MA~~	7-2014	~~S. Mallet, LPN~~		~~C. Schmidt, LPN~~	7-2014
	A. Cooley, LPN	7-2014	R. Malone, LPN		P. Taylor, RN	7-2014
	~~S. Deeds, LPN~~	7-2014	C. Marria, LPN		A. Thurber, LPN	7-2014
	J. Drake, LPN	7-2014	T. Mccall, LPN		F. Valenzuela, RN	7-2014
	V. Ferro, LPN	7-2014	K. Murray, RN		S. Vasquez, C N A	7-2014
	~~L. Green, RN~~	7-2014	A. Nisby, LPN		~~L. Whitworth, RN~~	7-2014
	T. Hall, LPN	7-2014	M. Palocsay, RN		C. Wilcox C N A	7-2014
	~~S. Harrod, PhT~~	7-2014	S. Patterson, LPN		C. Wilson, LPN	7-2014
	L. Hill, PhT	7-2014	S. Perus, LPN		W. Wingert, RN, DON	7-2014
	A. Huddleston, C N A	7-2014	H. Pierce, LPN		C. Young, LPN	7-2014
	L. Moser, CNA	7-2014	S. Harrod, PhT		K. Pettycrew	7-2014
		7-2014	S. Kelly, RMA		L. Dougherty, LPN	7-2014

Date/Time		NOTES
7-3-14	AM	Absent for pill pass
7-13-14	AM	Absent for KP

ER 2047

ER 2048

MEDICATION ADMINISTRATION RECORD

Facility: **Month:**

Init.	Drug - Dose - Mode - Interval	HR
	EDMO, MASON 94691 SPIRONOLACTONE (UD) 25 MG TABS (ALDACTONE UD) Rx: 31098184 WHINNERY,CATHERINE O/D: 07/03/14 D/C: 07/17/14 TAKE 1 TAB BY MOUTH TWICE DAILY FOR 14 DAYS >> MAY CAUSE DIZZINESS << 7-8-1446 6340- MAIN	AM K O P PM K O P
	Aldactone 50 mg po BID x 30 days to start 7/23 NOTE START DATE Prescriber Whinnery Order Date 7/3 Start Date 7/23 Stop Date 8/23	AM K PM P
	Aldactone 100 mg po BID x 90 days NOTE START DATE Prescriber Whinnery Order Date 7/3 Start Date 8/24 Stop Date 11/24	K O P
	EDMO, MASON 94691 CALCIUM CARB 1250MG/VIT D 1250 MG TABS (OSCAL-D 500) Rx: 31098161 WHINNERY,CATHERINE O/D: 07/03/14 D/C: 01/29/15 TAKE 1 TAB BY MOUTH DAILY FOR 210 DAYS 7-8-1446 6340- MAIN	K O P
	EDMO, MASON 94691 ASPIRIN EC 81 MG TBEC (ECOTRIN (ASA-EC)) Rx: 31098135 WHINNERY,CATHERINE O/D: 07/03/14 D/C: 02/02/15 TAKE 1 TAB BY MOUTH DAILY FOR 210 DAYS>> DO NOT CRUSH << 7-8-1446 6340- MAIN	K O P
	20loft 100 mg po qam x120d 31160856 Prescriber Eliason Order Date 7-16-14 Start Date 7-16-14 Stop Date 11-16-141	A

Diagnosis:

Allergies: NKDA

94691

DOB/Inmate #: [redacted] Location:

Name: Mason Edmo

#3150 REV 4/10

Medication Administration Record

Documentation Codes	Staff Signature		Date	Initials	Staff Signature		Date	Initials
	A. Benton, LPN	7-2014	K. Hyatt, LPN	7-2014	J. Prudhomme, LPN	7-2014		
	A. Beshears, RN	7-2014	A. Ing, ~~LPN~~ RN	7-2014	~~D. Rainier, LPN~~	7-2014		
D/C - Discont	~~S. Blackburn, LPN~~	7-2014	D. Jensen, LPN	7-2014	C. Read, LPN	7-2014		
	C. Brenenstahl, dialysis tech	7-2014	~~S. Kelly, PhT~~	7-2014	E. Reed, LPN	7-2014		
R - Refused	~~C. Brewer, RN~~	7-2014	~~J. King, LPN~~	7-2014	~~J. Rovard, CMS~~	7-2014		
A - Absent	L. Brown, LPN	7-2014	S. Kitto, RN	7-2014	~~R. Robinson, RN~~	7-2014		
	G. Capshaw, RN	7-2014	K. Larsen, LPN	7-2014	G. Rodriguez, LPN	7-2014		
O - Other	L. Carlson, RN, DON	7-2014	T. Lee, RN	7-2014	J. Savell, LPN	7-2014		
	T. Case, LPN	7-2014	D. Luna, LPN	7-2014	L. Schindele, C N A	7-2014		
	~~P. Cleveland, MA~~	7-2014	~~S. Mallet, LPN~~ [redacted]	7-2014	~~C. Schmidt, LPN~~	7-2014		
	A. Cooley, LPN	7-2014	R. Malone, LPN	7-2014	P. Taylor, RN	7-2014		
	~~S. Deeds, LPN~~	7-2014	C. Marria, LPN	7-2014	A. Thurber, LPN	7-2014		
	~~J. Drake, LPN~~	7-2014	~~T. Mccall, LPN~~	7-2014	~~F. Valenzuela, RN~~	7-2014		
	V. Ferro, LPN	7-2014	K. Murray, RN	7-2014	S. Vasquez, C N A	7-2014		
	~~L. Green, RN~~	7-2014	A. Nisby, LPN	7-2014	~~L. Whitworth, RN~~	7-2014		
	~~T. Hall, LPN~~	7-2014	~~M. Palocsay, RN~~	7-2014	~~C. Wilcox C N A~~	7-2014		
	~~S. Harrod, PhT~~	7-2014	S. Patterson, LPN	7-2014	C. Wilson, LPN	7-2014		
	L. Hill, PhT	7-2014	S. Perus, LPN	7-2014	W. Wingert, RN, DON	7-2014		
	~~A. Huddleston, C N A~~	7-2014	~~H. Pierce, LPN~~	7-2014	~~C. Young, LPN~~	7-2014		
Date/Time	L. Moser, CNA	7-2014	S. Harrod, MA	7-2014	K. Petty CNA	7-2014		
7-23-14	AR	7-2014	S. Kelly, RMA	7-2014	R. Daugherty, RN, RD	7-2014		

Date/Time	NOTES
7-23-14 AR	Absent for pill pass AR

Pg:301
Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID **Month:** August 2014

Init	Drug - Dose - Mode - Interval	HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	ASPIRIN EC 81 MG TBEC ~ECOTRIN ~ 30 V TAKE 1 TAB BY MOUTH DAILY FOR 210 DAYS>> DO NOT CRUSH << Prescriber WHINNERY,CATHERINE Rx#31098135 Order Date 07/03/14 Start Date 7/8/14 Stop Date 02/02/15	K O P													1		30																
	CALCIUM CARB 1250MG/VIT D 1250 MG TABS ~OSCAL-D 500~ 30 V TAKE 1 TAB BY MOUTH DAILY FOR 210 DAYS Prescriber WHINNERY,CATHERINE Rx#31098161 Order Date 07/03/14 Start Date 7/4/14 Stop Date 01/29/15	K O P													1		30																
	ESTRADIOL 1 MG TABS ~ESTRACE~ 7/7 #90 TAKE 3 TABS (3MG) BY MOUTH DAILY FOR 90 DAYS **APPROVED** Prescriber POULSON,WILLIAM NP Rx#30915124 Order Date 06/10/14 Start Date 6/11/14 Stop Date 08/01/14	K O P		STOP	Start new order																												
	ESTRADIOL 1 MG TABS ~ESTRACE~ TAKE 3 TABS (3MG) BY MOUTH EVERY DAY FOR 90 DAYS **APPROVED** Prescriber WHINNERY,CATHERINE Rx#31107444 Order Date 08/02/14 Start Date 8/2/14 Stop Date 10/31/14	K O P	→	→	→	→	→	→	→	→	→	→	→	→	1		30																
	SERTRALINE HCL 100 MG TABS ~ZOLOFT~ TAKE 1 TAB BY MOUTH EACH MORNING FOR 120 DAYS >> MAY CAUSE DROWSINESS << Prescriber ELIASON,SCOTT PSY Rx#31160856 Order Date 07/16/14 Start Date 7/16/14 Stop Date 11/13/14	AM										30 V																					
	Calcium Polycarb 625mg ~Fiber Lax~ Take 1 tab PO QD x 180 days Prescriber Gelok Order Date 8/22/14 Start Date 8/23/14 Stop Date 2/18/15	K O P																															

Inm. Sig:
DATE:
Disp:
Staff:

[redacted]

Diagnosis: No Known Drug Allergy
Allergies:

94691 DOB/Inmate #:

6340- MAIN() Location:

EDMO, MASON Name:

PharmaCorr

#3150 REV 4/10

ER 2050

Medication Administration Record

Documentation Codes	Staff Signature	Date	Staff Signature	Date	Staff Signature	Date
	A. Benton, LPN	8-2014	K. Hyatt, LPN	8-2014	H. Pierce, LPN	8-2014
	A. Beshears, RN	8-2014	~~A. Ing, RN~~	8-2014	~~J. Prudhomme, LPN~~	8-2014
D/C - Discontinued	~~G. Blackburn, LPN~~	8-2014	D. Jensen, LPN	8-2014	D. Rainier, LPN	8-2014
	~~C. Brenenstahl, dialysis tech~~	8-2014	S. Kelly, RMA	8-2014	C. Read, LPN	8-2014
R - Refused	G. Brewer, RN	8-2014	~~J. King, LPN~~	8-2014	E. Reed, LPN	8-2014
	L. Brown, LPN	8-2014	~~S. Kitto, RN~~	8-2014	J. Revard, CMS	8-2014
A - Absent	~~G. Capshaw, RN~~	8-2014	K. Larsen, LPN	8-2014	~~G. Rodriguez, LPN~~	8-2014
O - Other	L. Carlson, RN, DON	8-2014	T. Lee, RN	8-2014	J. Savell, LPN	8-2014
	T. Case, LPN	8-2014	D. Luna, LPN	8-2014	~~L. Schindele, CNA~~	8-2014
	~~P. Cleveland, MA~~	8-2014	S. Mallet, LPN	8-2014	C. Schmidt, LPN	8-2014
	A. Cooley, LPN	8-2014	C. Marria, LPN	8-2014	P. Taylor, RN	8-2014
	R. Daugherty, LPN	8-2014	T. Mccall, LPN	8-2014	A. Thurber, LPN	8-2014
	~~S. Deeds, LPN~~	8-2014	L. Moser, C N A	8-2014	F. Valenzuela, RN	8-2014
	J. Drake, LPN	8-2014	K. Murray, RN	8-2014	~~J. Vasquez, CNA~~	8-2014
	V. Ferro, LPN	8-2014	A. Nisby, LPN	8-2014	~~L. Whitworth, RN~~	8-2014
	~~L. Green, RN~~ L. Green, RN	8-2014	M. Palocsay, RN	8-2014	C. Wilcox C N A	8-2014
	T. Hall, LPN	8-2014	S. Patterson, LPN	8-2014	~~C. Wilson, LPN~~ C. Wilson, LPN	8-2014
	S. Harrod, MA	8-2014	S. Perus, LPN	8-2014	W. Wingert, RN, DON	8-2014
	L. Hill, PhT	8-2014	~~K. Petty, CNA~~	8-2014	C. Young, LPN	8-2014
Date/Time	A. Huddleston, C N A	8-2014	NOTES	8-2014		8-2014
	M. Bryant RN	8-2014		8-2014		8-2014

Date/Time		Notes
8/2	AM	Refused Sertraline 100mg, Refusal signed K.
8-3-14	AM	Absent for pill pass DS
8.4.14	AM	absent [illegible]
8.5.14		Pt Refused Meds — [illegible]
8-6-14	AM	Absent for pill pass I/M NON-COMPLIANT WITH MEDICATION. PROVIDER NOTIFIED DS
8.8.14	AM	Pt has signed stated that a Refusal has been signed for Sertraline 100mg [illegible] Refused Meds
8/9/14	AM	Refused AM meds [illegible]
8-10-14	AM	Absent for pill pass DS I/M NON-COMPLIANT WITH MEDICATION. PROVIDER NOTIFIED DS
8.11.14	AM	Pt Absent for AM Meds — [illegible]
8/12/14	AM	absent for pill [illegible]
8-15-14	AM	Absent for pill pass DS

Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID **Month:** August 2014

Init.	Drug - Dose - Mode - Interval	HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	SPIRONOLACTONE 100 MG TABS ~ALDACTONE~ TAKE 1 TAB BY MOUTH TWICE DAILY FOR 90 DAYS >> MAY CAUSE DIZZINESS << Prescriber WHINNERY,CATHERINE Rx#31106978 Order Date 08/17/14 Start Date 8/24/14 Stop Date 11/15/14	K O P																			LO				START								
	SPIRONOLACTONE 50 MG TABS ~ALDACTONE~ 7/24 #60 TAKE 1 TAB BY MOUTH TWICE DAILY FOR 30 DAYS >> MAY CAUSE DIZZINESS << Prescriber WHINNERY,CATHERINE Rx#31106952 Order Date 07/18/14 Start Date 7/23/14 Stop Date 08/17/14	K O P																		STOP	Start new order												
LO	Parason Forte 500mg PO QHS x 3 days Prescriber Poulson Order Date 8.25.14 Start Date 8.25.14 Stop Date 8.27.14	P																									LV 3			STOP			
LO	Naproxen 500mg 1/2 - 1 tab PO BID X30days #30/month Prescriber Poulson Order Date 8.25.14 Start Date 8.25.14 Stop Date 9.24.14	K S P	# 30 given in clinic (0 refills)																															
LO	EDMO, MASON 94691 MICONAZOLE TOPICAL (30GM) 2% CREA (MONISTAT-DERM) Rx: 31422789 POULSON,WILLIAM NP O/D: 08/26/14 D/C: 10/16/14 APPLY TO AFFECTED AREA TWICE DAILY FOR 3 WEEKS THEN DAILY AS NEEDED THEREAFTER FOR 30 DAYS >> FOR EXTERNAL USE ONLY << 8.27.14 6340- MAIN	K O P																															
	Prescriber Order Date Start Date Stop Date																																

Diagnosis: No Known Drug Allergy | 94691 | 6340- MAIN() | EDMO, MASON

Allergies: | DOB/Inmate #: | Location: | Name: PharmaCorr

#3150 REV 4/10

ER 2052

Medication Administration Record

Documentation Codes	Staff Signature	Date	Initials	Staff Signature	Date	Initials
A. Benton, LPN		K. Hyatt, LPN			H. Pierce, LPN	
A. Beshears, RN		~~A. Ing, RN~~			~~J. Prathomme, LPN~~	
D/C - Discon ~~G. Blackburn, LPN~~		D. Jensen, LPN			D. Rainier, LPN	
~~C. Brenenstuhl, dialysis tech~~		S. Kelly, RMA			C. Read, LPN	
R - Refused ~~G. Brewer, RN~~		J. King, LPN			E. Reed, LPN	
A - Absent L. Brown, LPN		~~S. Kitto, RN~~			J. Revard, CMS	
~~G. Capshaw, RN~~		K. Larsen, LPN			~~G. Rodriguez, LPN~~	
O - Other L. Carlson, RN, DON		T. Lee, RN			J. Savell, LPN	
T. Case, LPN		D. Luna, LPN			~~L. Schindele, CNA~~	
P. Cleveland, MA		S. Mallet, LPN			C. Schmidt, LPN	
A. Cooley, LPN		C. Marria, LPN			P. Taylor, RN	
R. Daugherty, LPN		T. Mccall, LPN			A. Thurber, LPN	
~~S. Deeds, LPN~~		L. Moser, CNA			F. Valenzuela, RN	
J. Drake, LPN		K. Murray, RN			~~S. Vasquez, CNA~~	
V. Ferro, LPN		A. Nisby, LPN			~~L. Whitworth, RN~~	
~~L. Green, RN~~ L. Green, RN		M. Palocsay, RN			C. Wilcox CNA	
T. Hall, LPN		S. Patterson, LPN			~~C. Wilson, LPN~~ C. Wilson, LPN	
S. Harrod, MA		S. Perus, LPN			~~W. Wingert, RN, DON~~	
L. Hill, PhT		~~K. Petty, CNA~~			C. Young, LPN	
A. Huddleston, CNA						
Date/Time M. BRYANT RN		**NOTES**				

8/26/14 pm Absent OR
8/29/14 pm Absent OR

ER 2053

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID **Month:** September 2014

Init.	Drug - Dose - Mode - Interval	HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	ASPIRIN EC 81 MG TBEC ~ECOTRIN ~ #30 8/15 TAKE 1 TAB BY MOUTH DAILY FOR 210 DAYS>> DO NOT CRUSH << Prescriber WHINNERY,CATHERINE Rx#31098135 Order Date 07/03/14 Start Date 7/8/14 Stop Date 02/02/15	K O P							30				#30 dr	9-7-14 Edmo																			
	CALCIUM CARB 1250MG/VIT D 1250 MG TABS ~OSCAL-D 500~ TAKE 1 TAB BY MOUTH DAILY FOR 210 DAYS #30 8/15 Prescriber WHINNERY,CATHERINE Rx#31098161 Order Date 07/03/14 Start Date 7/4/14 Stop Date 01/29/15	K O P							30				#30 dr	9-7-14 Edmo									#30 9/27/14										
	ESTRADIOL 1 MG TABS ~ESTRACE~ #30 8/15 TAKE 3 TABS (3MG) BY MOUTH EVERY DAY FOR 90 DAYS **APPROVED** Prescriber WHINNERY,CATHERINE Rx#31107444 Order Date 08/02/14 Start Date 8/2/14 Stop Date 10/31/14	K O P							90				#90 dr	9-7-14 Edmo															90				
	SERTRALINE HCL 100 MG TABS ~ZOLOFT~ TAKE 1 TAB BY MOUTH EACH MORNING FOR 120 DAYS >> MAY CAUSE DROWSINESS << Prescriber ELIASON,SCOTT PSY Rx#31160856 Order Date 07/16/14 Start Date 7/16/14 Stop Date 11/13/14	AM	ø	ø	ø																		New Order										
	SPIRONOLACTONE 100 MG TABS ~ALDACTONE~ 8/24 #60 TAKE 1 TAB BY MOUTH TWICE DAILY FOR 90 DAYS >> MAY CAUSE DIZZINESS << Prescriber WHINNERY,CATHERINE Rx#31106978 Order Date 08/17/14 Start Date 8/24/14 Stop Date 11/15/14	K O P											9-17-14 #60 edmo																				
	EDMO, MASON 94691 CALCIUM POLYCARB (60/BOX) 625 MG TABS (FIBER-LAX) Rx: 31403082 ELOK,CHRISTIAN,NP O/D: 08/22/14 Pre TAKE 1 TAB BY MOUTH EVERY DAY FOR 180 DAYS TAKE WITH GLASS OF WATER D/C: 02/18/15 Ord 8/23 PC 6340- MAIN	K O P							30																								

Diagnosis: No Known Drug Allergy

Allergies:

94691 DOB/Inmate #:

6340- MAIN() Location:

EDMO, MASON 1/2 Name:

PharmaCorr

#3150 REV 4/10

ER 2054

Medication Administration Record

Documentation Codes	Staff Signature	Date	Initials	Staff Signature	Date	Initials
	C. Ahearn, RN		M. Hickman, LPN		H. Pierce, LPN	
	A. Benton, LPN		L. Hill, PHT		[illegible]	
D/C - Discontinued Order	A. Bishears, RN		A. Huddleston, C N A		D. Rainier, LPN	
	~~G. Blackburn, LPN~~		K. Hyatt, LPN		C. Read, LPN	
R - Refused	C. Brenenstahl, dialysis tech		D. Jensen, LPN		[illegible]	
A - Absent	G. Brewer, RN		S. Kelly, RMA		J. Revard, CMS	
	L. Brown, LPN		[illegible]		P. Roberson, LPN	
O - Other	~~M. Bryant, RN~~		S. Kitto, RN		G. Rodriguez, LPN	
	G. Capshaw, RN		K. Larsen, LPN		J. Savell, LPN	
	~~L. Carlson, RN, DON~~		T. Lee, RN		~~C. Schmidt, LPN~~	
	T. Case, LPN		D. Luna, LPN		A. Thurber, LPN	
	P. Cleveland, MA		S. Mallet, LPN		F. Valenzuela, RN	
	A. Cooley, LPN		C. Marria, LPN		L. Whitworth, RN	
	R. Daugherty, LPN		T. Mccall, LPN		C. Wilcox C N A	
	J. Drake, LPN		L. Moser, C N A		C. Wilson, LPN	
	V. Ferro, LPN		K. Murray, RN		[illegible]	
	L. Green, RN		A. Nisby, LPN		~~C. Young, LPN~~	
	T. Hall, LPN		S. Patterson, LPN			
	S. Harrod, MA		S. Perus, LPN			

Date/Time		NOTES
9-8-14	AM	Absent for pill pass DF
9-14-14	AM	Absent for PM Pass DF

ER 2055

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID **Month:** September 2014

Init.	Drug - Dose - Mode - Interval	HR	Days 1–31
HL	EDMO, MASON #30 given in clinic 94691 NAPROXEN 250 MG TABS (NAPROSYN) Rx: 31413553 O/D: 08/25/14 POULSON,WILLIAM NP D/C: 09/24/14 TAKE 1-2 TABS BY MOUTH TWICE DAILY FOR 30 DAYS (#60 TABS OF 250MG) >> TAKE WITH FOOD << 8-26-14 US 6340- MAIN	KOP	25: S T O P
AN	Miconazole topical 2% apply to affected area twice daily x 30 days Prescriber Poulson Order Date 8/26/14 Start Date 8/26/14 Stop Date 10/16/14	KOP	7–9: Given #1 9-7-14 DY; 17–23: #1 9/19/14 [illegible]
JJ	Zoloft 150mg po q am x 120d Prescriber Eliason Order Date 9-17-14 Start Date 9-17-14 Stop Date 1-17-15	A	1–16: ——> #4; 17–31: Zoloft [illegible] w/ (A) [illegible]
	Prescriber Order Date Start Date Stop Date		
	Prescriber Order Date Start Date Stop Date		
	Prescriber Order Date Start Date Stop Date		

Diagnosis:

Allergies: NKDA

DOB/Inmate #: 94691 [redacted]

Location: 6340- MAIN

Name: EDMO, MASON 2/2

#3150 REV 4/10

Medication Administration Record

Documentation Codes	Staff Signature	Date	Initials	Staff Signature	Date	Initials
A. Benton, LPN		8-2014	K. Hyatt, LPN		8-2014	H. Pierce, LPN		8-2014
A. Beshears, RN		8-2014	~~A. Ing, RN~~		8-2014	~~J. Prudhomme, LPN~~		8-2014
~~G. Blackburn, LPN~~		8-2014	D. Jensen, LPN		8-2014	D. Rainier, LPN		8-2014
D/C - Discontinued Order ~~C. Brenenstahl, dialysis tech~~		8-2014	S. Kelly, RMA		8-2014	C. Read, LPN		8-2014
G. Brewer, RN R - Refused		8-2014	J. King, LPN		8-2014	E. Reed, LPN		8-2014
L. Brown, LPN		8-2014	~~S. Kitto, RN~~		8-2014	J. Revard, CMS		8-2014
~~G. Capshaw, RN~~ A - Absent		8-2014	K. Larsen, LPN		8-2014	G. Rodriguez, LPN		8-2014
L. Carlson, RN, DON O - Other		8-2014	T. Lee, RN		8-2014	J. Savell, LPN		8-2014
T. Case, LPN		8-2014	D. Luna, LPN		8-2014	~~L. Schindele, C N A~~		8-2014
P. Cleveland, MA		8-2014	S. Mallet, LPN		8-2014	C. Schmidt, LPN		8-2014
Cooley, LPN		8-2014	C. Marria, LPN		8-2014	P. Taylor, RN		8-2014
~~R. Daugherty, LPN~~		8-2014	T. Mccall, LPN		8-2014	A. Thurber, LPN		8-2014
~~S. Deeds, LPN~~		8-2014	L. Moser, C N A		8-2014	F. Valenzuela, RN		8-2014
J. Drake, LPN		8-2014	K. Murray, RN		8-2014	~~S. Vasquez, C N A~~		8-2014
V. Ferro, LPN		8-2014	A. Nisby, LPN		8-2014	~~L. Whitworth, RN~~		8-2014
~~L. Green, RN~~ L. Green, RN		8-2014	M. Palocsay, RN		8-2014	C. Wilcox C N A		8-2014
T. Hall, LPN		8-2014	S. Patterson, LPN		8-2014	~~C. Wilson, LPN~~ C. Wilson, LPN		8-2014
S. Harrod, MA		8-2014	S. Perus, LPN		8-2014	W. Wingert, RN, DON		8-2014
L. Hill, PhT		8-2014	~~K. Petty, C N A~~		8-2014	C. Young, LPN		8-2014
A. Huddleston, C N A		8-2014	~~C. Allearn, RN~~		8-2014	P. Roberson, LPN		8-2014
~~Date/Time~~		8-2014		NOTES	8-2014			8-2014

M. Hickman, LPN
9-21-14 AM Absent for Pill Pass DO
9-27-14 AM Absent for Pill Pass
9-28-14 AM Absent for Pill Pass

ER 2057

Pg:288
Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID **Month:** October 2014

Drug - Dose - Mode - Interval	HR	Notes (days 1–31)
SPIRONOLACTONE 100 MG TABS ~ALDACTONE~ 9/17 TAKE 1 TAB BY MOUTH TWICE DAILY FOR 90 DAYS >> MAY CAUSE DIZZINESS << #60 Prescriber WHINNERY,CATHERINE Rx#31106978 Order Date 08/17/14 Start Date 8/24/14 Stop Date 11/15/14	K O P	New order 10.13.14 Rx exchange Qty 60 of 100mg for 60 50mg
MICONAZOLE TOPICAL (30GM) 2% CREA ~MONISTAT-DERM~ #1 9/19 APPLY TO AFFECTED AREA TWICE DAILY FOR 3 WEEKS THEN DAILY AS NEEDED THEREAFTER FOR 30 DAYS >> FOR EXTERNAL USE ONLY << Prescriber POULSON,WILLIAM NP Rx#31422789 **PRN**PRN** Order Date 08/26/14 Start Date 8/26/14 Stop Date 10/16/14	K O P	10-4-14 #1
EDMO, MASON 94691 NAPROXEN 250 MG TABS (NAPROSYN) Rx: 31659051 O/D: 10/01/14 GELOK,CHRISTIAN,NP D/C: 03/30/15 TAKE 1 TAB BY MOUTH TWICE DAILY FOR 180 DAYS >> TAKE WITH FOOD << 10-2-14 6340- MAIN	K B P	10-30-14
EDMO, MASON 94691 SPIRONOLACTONE 50 MG TABS Rx: 31707371 (ALDACTONE) O/D: 10/09/14 WHINNERY,CATHERINE D/C: 05/07/15 TAKE 1 TAB BY MOUTH TWICE DAILY FOR 210 DAYS >> MAY CAUSE DIZZINESS << 6340- MAIN	K O P	#60 10/10/14 10.13.14 #60 issued
Estradiol 3mg Take 1 tab po daily x 90 days To start 10/31/14 APPROVED Prescriber Whinnery Order Date 10/8/14 Start Date 10-15-14 Stop Date 1-15-15	K O P	
Proscar 5mg Take 1 tab po daily x 90 days APPROVED Prescriber Whinnery Order Date 10/8/14 Start Date 10-15-14 Stop Date 1-15-15	K O P	10-17-14 #30

[redacted]

Diagnosis:
No Known Drug Allergy

Allergies:

DOB/Inmate #: 94691 Location: 6340- MAIN() Name: EDMO, MASON

#3150 REV 4/10

PharmaCorr

Medication Administration Record

Documentation Codes	Staff Signature	Date	Initials	Staff Signature	Date	Initials
	C. Ahearn, RN		T. Hall, LPN		S. Patterson, LPN	
	K. Barney, LPN		S. Harroc, MA		S. Perus, LPN	
D/C - Discontinued Order	A. Benton, LPN		M. Hickman, LPN		H. Pierce, LPN	
	A. Beshears, RN		L. Hill, PhT		J. Prudhomme, LPN	
R - Refused	G. Blackburn, LPN		A. Huddleston, C N A		D. Rainier, LPN	
A - Absent	C. Brenenstahl, dialysis tech		K. Hyatt, LPN		C. Read, LPN	
	G. Brewer, RN		D. Jensen, LPN		E. Reed, LPN	
O - Other	L. Brown, LPN		S. Kelly, RMA		P. Roberson, LPN	
	M. Bryant, RN		J. King, LPN		G. Rodriguez, LPN	
	G. Capshaw, RN		S. Kitto, RN		J. Savell, LPN	
	L. Carlson, RN, DON		K. Larsen, LPN		C. Schmidt, LPN	
	T. Case, LPN		T. Lee, RN		M. Shurtliff, RN	
	P. Cleveland, MA		D. Luna, LPN		F. Valenzuela, RN	
	A. Cooley, LPN		S. Mallet, LPN		D. Vogler, LPN	
	R. Daugherty, LPN		C. Marria, LPN		C. Wilcox C N A	
	J. Drake, LPN		T. Mccall, LPN		C. Wilson, LPN	
	V. Ferro, LPN		L. Moser, C N A		W. Wingert, RN, DON	
	L. Green, RN		K. Murray, RN		C. Young, LPN	
			A. Nisby, LPN			

Date/Time	NOTES

ER 2059

Pg:287
Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID **Month:** October 2014

Drug - Dose - Mode - Interval	HR	Notes (days 1–31)
ASPIRIN EC 81 MG TBEC ~ECOTRIN~ #30 9/7 TAKE 1 TAB BY MOUTH DAILY FOR 210 DAYS>> DO NOT CRUSH << Prescriber WHINNERY,CATHERINE Rx#31098135 Order Date 07/03/14 Start Date 7/8/14 Stop Date 02/02/15	K O P	30 ✓ 10/22/14 #38
CALCIUM CARB 1250MG/VIT D 1250 MG TABS ~OSCAL-D 500~ TAKE 1 TAB BY MOUTH DAILY FOR 210 DAYS 9/7 #30 Prescriber WHINNERY,CATHERINE Rx#31098161 Order Date 07/03/14 Start Date 7/4/14 Stop Date 01/29/15	K O O	30 ✓ 10/22/14 #30
CALCIUM POLYCARB (60/BOX) 625 MG TABS ~FIBER-LAX~ TAKE 1 TAB BY MOUTH EVERY DAY FOR 180 DAYS TAKE WITH GLASS OF WATER 9/6 #60 Prescriber GELOK,CHRISTIAN,NP Rx#31403082 Order Date 08/22/14 Start Date 8/23/14 Stop Date 02/18/15	K O P	
ESTRADIOL 1 MG TABS ~ESTRACE~ #90 9/7 TAKE 3 TABS (3MG) BY MOUTH EVERY DAY FOR 90 DAYS **APPROVED** Prescriber WHINNERY,CATHERINE Rx#31107444 Order Date 08/02/14 Start Date 9/7/14 Stop Date 10/31/14	K O P	10-4-14 #90 New order
SERTRALINE HCL 50 MG TABS ~ZOLOFT~ TAKE 3 TABS (150MG) BY MOUTH EACH MORNING FOR 120 DAYS >> MAY CAUSE DROWSINESS << Prescriber ELIASON,SCOTT PSY Rx#31567862 Order Date 09/17/14 Start Date 9/17/14 Stop Date 01/15/15	3AM	90
Prescriber Order Date Start Date Stop Date		

Diagnosis: No Known Drug Allergy

Allergies:

[redacted] 94691 — DOB/Inmate #:
6340- MAIN() — Location:
EDMO, MASON — Name:

PharmaCorr

#3150 REV 4/10

ER 2061

Medication Administration Record

Documentation Codes	Staff Signature	Date	Initials	Staff Signature	Date	Initials
	C. Ahearn, RN		T. Hall, LPN		S. Patterson, LPN	
	K. Barney, LPN		S. Harrod, MA		S. Perus, LPN	
D/C - Discontinued Order	A. Bowden, LPN		M. Hickman, LPN		H. Pierce, LPN	
	A. Beshears, RN		L. Hill, PhT		J. Prudhomme, LPN	
R - Refused	G. Blackburn, LPN		A. Huddleston, C N A		D. Palmer, LPN	
A - Absent	C. Brenenstahl, dialysis tech		K. Hyatt, LPN		C. Read, LPN	
	G. Brewer, RN		D. Jensen, LPN		E. Reed, LPN	
O - Other	L. Brown, LPN		S. Kelly, RMA		P. Roberson, LPN	
	M. Bryant, RN		J. King, LPN		G. Rodriguez, LPN	
	G. Capshaw, RN		S. Kitto, RN		J. Savell, LPN	
	L. Carlson, RN, DON		K. Larsen, LPN		C. Schmidt, LPN	
	T. Case, LPN		T. Lee, RN		M. Shurtliff, RN	
	P. Cleveland, MA		R. Luna, RN		F. Valenzuela, RN	
	A. Cooley, LPN		S. Mallet, LPN		D. Vogler, LPN	
	R. Daugherty, LPN		C. Marria, LPN		C. Wilcox C N A	
	J. Drake, LPN		T. Mccall, LPN		C. Wilson, LPN	
	V. Ferro, LPN		L. Moser, C N A		W. Wingert, RN, DON	
	L. Green, RN		K. Murray, RN		C. Young, LPN	
			A. Nisby, LPN			

Date/Time		NOTES
10/8	AM	Absent PC

MEDICATION ADMINISTRATION RECORD

Facility: M **6340-** IDAHO STATE CORR INST (ISCI) ID **Month:** November 2014

Init.	Drug - Dose - Mode - Interval	HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	ASPIRIN EC 81 MG TBEC ~ECOTRIN ~ 10/22 TAKE 1 TAB BY MOUTH DAILY FOR 210 DAYS>> DO NOT CRUSH << #30 Prescriber WHINNERY,CATHERINE Rx#31098135 Order Date 07/03/14 Start Date 7/8/14 Stop Date 02/02/15	K O P																	30														
	CALCIUM CARB 1250MG/VIT D 1250 MG TABS ~OSCAL-D 500~ 10/22 TAKE 1 TAB BY MOUTH DAILY FOR 210 DAYS #30 Prescriber WHINNERY,CATHERINE Rx#31098161 Order Date 07/03/14 Start Date 7/4/14 Stop Date 01/29/15	K O P																	30														
	CALCIUM POLYCARB (60/BOX) 625 MG TABS ~FIBER-LAX~ 9/6 #60 TAKE 1 TAB BY MOUTH EVERY DAY FOR 180 DAYS TAKE WITH GLASS OF WATER Prescriber GELOK,CHRISTIAN,NP Rx#31403082 Order Date 08/22/14 Start Date 8/23/14 Stop Date 02/18/15	K O P																	1														
	ESTRADIOL 1 MG TABS ~ESTRACE~ 9/27 TAKE 3 TABS (3MG) BY MOUTH DAILY FOR 90 DAYS **APPROVED** (NOTE START DATE) *Approved* Prescriber WHINNERY,CATHERINE Rx#31737713 Order Date 10/31/14 Start Date 10/31/14 Stop Date 01/29/15	K O P									1		90																				
	FINASTERIDE 5 MG TABS ~PROSCAR~ 10/10 #30 TAKE 1 TAB BY MOUTH DAILY FOR 90 DAYS **APPROVED** >>WOMEN OF CHILD BEARING AGE SHOULD NOT HANDLE THIS DRUG<< *Approved* Prescriber WHINNERY,CATHERINE Rx#31737719 Order Date 10/08/14 Start Date Stop Date 01/06/15	K O P									1		30																				
	Prescriber Order Date Start Date Stop Date																																

[redacted] **94691**

Diagnosis: No Known Drug Allergy

Allergies:

DOB/Inmate #:

6340- MAIN() Location:

EDMO, MASON Name:

PharmaCorr

#3150 REV 4/10

ER 2062

Medication Administration Record

Documentation Codes	Staff Signature	Initials	Date
	~~C. Akeorn, RN~~		11-2014
	K. Barney, LPN	KB	11-2014
D/C - Discontinued Order	A. Benton, LPN	AB	11-2014
	A. Beshears, RN	AB	11-2014
R - Refused	G. Blackburn, LPN	GB	11-2014
	C. Brenenstahl, dialysis tech	CB	11-2014
A - Absent	G. Brewer, RN	GB	11-2014
	L. Brown, LPN	LB	11-2014
O - Other	~~M. Bryant, RN~~		11-2014
	G. Capshaw, RN	GC	11-2014
	L. Carlson, RN, DON	LC	11-2014
	T. Case, LPN	TC	11-2014
	P. Cleveland, MA	PC	11-2014
	A. Cooley, LPN	AC	11-2014
	R. Daugherty, LPN	RD	11-2014
	J. Drake, LPN	JD	11-2014
	V. Ferro, LPN	VF	11-2014
	L. Green, RN	LG	11-2014
			11-2014
			11-2014
			11-2014
			11-2014

Staff Signature	Initials	Date
T. Hall, LPN	TH	11-2014
S. Harrod, MA	SH	11-2014
L. Hill, PhT	LH	11-2014
A. Huddleston, C N A	AH	11-2014
K. Hyatt, LPN	KH	11-2014
D. Jensen, LPN	DJ	11-2014
S. Kelly, RMA	SK	11-2014
~~J. King, LPN~~		11-2014
S. Kitto, RN	SK	11-2014
K. Larsen, LPN	KL	11-2014
T. Lee, RN	TL	11-2014
~~D. Luna, LPN~~		11-2014
S. Mallet, LPN	SM	11-2014
C. Marria, LPN	CM	11-2014
T. Mccall, LPN	TM	11-2014
L. Moser, C N A	LM	11-2014
K. Murray, RN	KM	11-2014
		11-2014
		11-2014
		11-2014
		11-2014

Staff Signature	Initials	Date
A. Nisby, LPN	AN	11-2014
S. Patterson, LPN	SP	11-2014
S. Perus, LPN	SP	11-2014
H. Pierce, LPN	HP	11-2014
~~J. Prudhomme, LPN~~		11-2014
D. Rainier, LPN	DR	11-2014
C. Read, LPN	CR	11-2014
E. Reed, LPN	ER	11-2014
G. Rodriguez, LPN	GR	11-2014
J. Savell, LPN	JS	11-2014
~~C. Schmidt, LPN~~		11-2014
F. Valenzuela, RN	FV	11-2014
R. Witschen, LPN	RW	11-2014
C. Wilcox C N A	CW	11-2014
~~C. Wilson, LPN~~		11-2014
W. Wingert, RN, DON	WW	11-2014
C. Young, LPN	CY	11-2014
A Thurber	AT	11-2014
		11-2014
		11-2014
		11-2014

Date/Time	NOTES

ER 2063

Pg:295
Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID **Month:** November 2014

Init.	Drug - Dose - Mode - Interval	HR
	NAPROXEN 250 MG TABS ~NAPROSYN~ 10/30 #60 TAKE 1 TAB BY MOUTH TWICE DAILY FOR 180 DAYS >> TAKE WITH FOOD << Prescriber GELOK,CHRISTIAN,NP Rx#31659051 Order Date 10/01/14 Start Date 10/2/14 Stop Date 03/30/15	K O P
	SERTRALINE HCL 50 MG TABS ~ZOLOFT~ TAKE 3 TABS (150MG) BY MOUTH EACH MORNING FOR 120 DAYS >> MAY CAUSE DROWSINESS << Prescriber ELIASON,SCOTT PSY Rx#31567862 Order Date 09/17/14 Start Date 9/17/14 Stop Date 01/15/15	AM
	SPIRONOLACTONE 50 MG TABS ~ALDACTONE~ 10/13 #60 TAKE 1 TAB BY MOUTH TWICE DAILY FOR 210 DAYS >> MAY CAUSE DIZZINESS << Prescriber WHINNERY,CATHERINE Rx#31707371 Order Date 10/09/14 Start Date 10/9/14 Stop Date 05/07/15	K O P
	EDMO, MASON 94691 AMITRIPTYLINE HCL 10 MG TABS (ELAVIL) Rx: 31942352 POULSON,WILLIAM NP O/D: 11/17/14 D/C: 02/15/15 TAKE 1 TAB BY MOUTH AT BEDTIME FOR 90 DAYS >> MAY CAUSE DROWSINESS << <Avoid Excessive Sun Exposure> 11-20 6340- MAIN	8M
	Prescriber Order Date Start Date Stop Date	
	Prescriber Order Date Start Date Stop Date	

Handwritten in day columns: Naproxen — "D/C per Poulson"; Spironolactone — "K 60 #60 diverted 11-03-14".

[redacted]

Diagnosis: No Known Drug Allergy
Allergies:

94691 — DOB/Inmate #: | 6340- MAIN() — Location: | EDMO, MASON — Name:

PharmaCorr
#3150 REV 4/10

Medication Administration Record

Documentation Codes	Staff Signature	Initials	Signature	Date	Staff Signature	Initials	Signature	Date	Staff Signature	Initials	Signature	Date
	~~C. Ahearn, RN~~			11-2014	T. Hall, LPN	TH		11-2014	A. Nisby, LPN			11-2014
	~~K. Barney, LPN~~			11-2014	~~S. Harrod, MA~~	SH		11-2014	~~S. Patterson, LPN~~			11-2014
D/C - Discontinued Order	~~A. Benton, LPN~~	AB		11-2014	L. Hill, PhT	LH		11-2014	S. Perus, LPN			11-2014
	A. Beshears, RN	AB		11-2014	A. Huddleston, C N A	AH		11-2014	H. Pierce, LPN	HP		11-2014
R - Refused	~~G. Blackburn, LPN~~	GB		11-2014	~~K. Hyatt, LPN~~	KH		11-2014	~~J. Prudhomme, LPN~~			11-2014
	C. Brenenstahl, dialysis tech	CB		11-2014	D. Jensen, LPN	DJ		11-2014	D. Rainier, LPN	DR		11-2014
A - Absent	~~G. Brewer, RN~~	GB		11-2014	~~S. Kelly, RMA~~	SK		11-2014	~~C. Read, LPN~~	CR		11-2014
O - Other	L. Brown, LPN	LB		11-2014	~~J. King, LPN~~			11-2014	E. Reed, LPN			11-2014
	~~M. Bryant, RN~~			11-2014	S. Kitto, RN	SK		11-2014	G. Rodriguez, LPN			11-2014
	~~G. Capshaw, RN~~			11-2014	~~K. Larsen, LPN~~			11-2014	~~J. Savell, LPN~~	JS		11-2014
	L. Carlson, RN, DON	LC		11-2014	T. Lee, RN			11-2014	~~C. Schmidt, LPN~~			11-2014
	T. Case, LPN			11-2014	~~D. Lane, LPN~~			11-2014	F. Valenzuela, RN			11-2014
	P. Cleveland, MA	PC		11-2014	S. Mallet, LPN	SM	Smallet	11-2014	~~R. Witschen, LPN~~	RW		11-2014
	A. Cooley, LPN			11-2014	C. Marria, LPN	CM		11-2014	C. Wilcox, C N A			11-2014
	R. Daugherty, LPN			11-2014	T. Mccall, LPN	TM	TMcCall	11-2014	~~C. Wilson, LPN~~			11-2014
	~~L. Drake, LPN~~			11-2014	~~L. Moser, C N A~~	LM		11-2014	W. Wingert, RN, DON			11-2014
	V. Ferro, LPN			11-2014	K. Murray, RN	KM	KMurray	11-2014	C. Young, LPN			11-2014
	L. Green, RN			11-2014				11-2014	A Thurber	AT		11-2014
				11-2014				11-2014				11-2014

Date/Time		NOTES
11/27/14	am / AM	~~Refused~~ C Wilson LPN [illegible] pills ~~[illegible]~~
11/30/14	pm	Refused . CW

Pg:298
Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M **6340-** IDAHO STATE CORR INST (ISCI) ID **Month:** December 2014

Init.	Drug - Dose - Mode - Interval	HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
VS	**AMITRIPTYLINE HCL 10 MG TABS ~ELAVIL~** TAKE 1 TAB BY MOUTH AT BEDTIME FOR 90 DAYS >> MAY CAUSE DROWSINESS << <Avoid Excessive Sun Exposure> Crush Prescriber POULSON,WILLIAM NP Rx#31942352 Order Date 11/17/14 Start Date 11-20-14 Stop Date 02/15/15	Q	9	(A)	(A)	(A)	(A)	(A)	(A)	(A)				D/C Per Towson 12/9/14 (Due to Nonadherence)																			
VS	**ASPIRIN EC 81 MG TBEC ~ECOTRIN ~** TAKE 1 TAB BY MOUTH DAILY FOR 210 DAYS>> DO NOT CRUSH << I 11-20 #30 Prescriber WHINNERY,CATHERINE Rx#31098135 Order Date 07/03/14 Start Date 7-8-14 Stop Date 02/02/15	K.O.P.													30 V																		
VS	**CALCIUM CARB 1250MG/VIT D 1250 MG TABS ~OSCAL-D 500~** TAKE 1 TAB BY MOUTH DAILY FOR 210 DAYS I 11-20 #30 Prescriber WHINNERY,CATHERINE Rx#31098161 Order Date 07/03/14 Start Date 7-4-14 Stop Date 01/29/15	K.O.P.													30 V																		
VS	**CALCIUM POLYCARB (60/BOX) 625 MG TABS ~FIBER-LAX~** TAKE 1 TAB BY MOUTH EVERY DAY FOR 180 DAYS TAKE WITH GLASS OF WATER I 11-20 #1 Prescriber GELOK,CHRISTIAN,NP Rx#31403082 Order Date 08/22/14 Start Date 8-22-14 Stop Date 02/18/15	K.O.P.																															
	ESTRADIOL 1 MG TABS ~ESTRACE~ TAKE 3 TABS (3MG) BY MOUTH DAILY FOR 90 DAYS **APPROVED** (NOTE START DATE) I 11-13 #90 Prescriber WHINNERY,CATHERINE Rx#31737713 Order Date 10/31/14 Start Date 10-31-14 Stop Date 01/29/15	K.O.P.					92 V																										
	Prescriber Order Date Start Date Stop Date																																

[redacted]

Diagnosis: No Known Drug Allergy

94691 6340- MAIN() **EDMO, MASON**

Allergies: DOB/Inmate #: Location: Name:

PharmaCorr

#3150 REV 4/10

ER 2066

Medication Administration Record

Documentation Codes	Staff Signature		Date	Staff Signature		Date	Staff Signature		Date	Initials
	~~Ahearn, RN~~		12-2014	L. Green, RN		12-2014	K. Murray, RN		12-2014	
	~~K. Barney, LPN~~	KB	12-2014	~~T. Hall, LPN~~		12-2014	A. Nisby, LPN		12-2014	
D/C - Discontinued Order	~~A. Benton, LPN~~		12-2014	S. Harrod, MA	SH	12-2014	S. Patterson, LPN		12-2014	
	A. Beshears, RN		12-2014	L. Hill, PhT		12-2014	S. Perus, LPN		12-2014	
R - Refused	~~G. Blackburn, LPN~~		12-2014	A. Huddleston, C N A		12-2014	H. Pierce, LPN		12-2014	
	C. Brenenstahl, dialysis tech		12-2014	K. Hyatt, LPN	KH	12-2014	J. Prudhomme, LPN		12-2014	
A - Absent	~~G. Brewer, RN~~		12-2014	~~D. Jensen, LPN~~		12-2014	D. Rainier, LPN		12-2014	
O - Other	L. Brown, LPN		12-2014	S. Kelly, RMA		12-2014	C. Read, LPN	OR	12-2014	
	~~M. Bryant, RN~~		12-2014	~~S. Kitto, RN~~		12-2014	E. Reed, LPN		12-2014	
	G. Capshaw, RN		12-2014	K. Larsen, LPN		12-2014	G. Rodriguez, LPN		12-2014	
	[redacted]		12-2014	T. Lee, RN		12-2014	J. Savell, LPN		12-2014	
	T. Case, LPN		12-2014	D. Luna, LPN		12-2014	F. Valenzuela, RN		12-2014	
	P. Cleveland, MA		12-2014	S. Mallet, LPN		12-2014	C. Wilcox C N A		12-2014	
	~~A. Cooley, LPN~~		12-2014	C. Marria, LPN		12-2014	C. Wilson, LPN		12-2014	
	R. Daugherty, LPN		12-2014	T. Mccall, LPN		12-2014	[redacted]		12-2014	
	J. Drake, LPN		12-2014	L. Moser, C N A		12-2014	~~C. Young, LPN~~		12-2014	
	V. Ferro, LPN		12-2014			12-2014	A. Thurber, LPN		12-2014	
	G. CATHERMAN LPN		12-2014			12-2014	D. Walthal, RN		12-2014	

Date/Time		NOTES
12/2/14	PM	Absent for pill pass
12/3/14	PM	Absent for PL
12/4		Absent PM
12/5/14	PM	absent for pill provider Notified
12/6/14	PM	absent for pill [illegible]
12/7/14	PM	absent for pills [illegible]
12/8/14	PM	absent for pill provider Notified [illegible]

Pg:299
Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID **Month:** December 2014

Init.	Drug - Dose - Mode - Interval	HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	FINASTERIDE 5 MG TABS ~PROSCAR~ TAKE 1 TAB BY MOUTH DAILY FOR 90 DAYS "APPROVED" >>WOMEN OF CHILD BEARING AGE SHOULD NOT HANDLE THIS DRUG<< Prescriber WHINNERY,CATHERINE Rx#31737719 Order Date 10/08/14 Start Date 10/9/14 Stop Date 01/06/15	K.O.P.					7 ✓ 30																										
	SERTRALINE HCL 50 MG TABS ~ZOLOFT~ TAKE 3 TABS (150MG) BY MOUTH EACH MORNING FOR 120 DAYS >> MAY CAUSE DROWSINESS << Prescriber ELIASON,SCOTT PSY Rx#31567862 Order Date 09/17/14 Start Date 9-17-14 Stop Date 01/15/15	A															NEW ORDER															
	SPIRONOLACTONE 50 MG TABS ~ALDACTONE~ TAKE 1 TAB BY MOUTH TWICE DAILY FOR 210 DAYS >> MAY CAUSE DIZZINESS << Prescriber WHINNERY,CATHERINE Rx#31707371 Order Date 10/09/14 Start Date 10/9/14 Stop Date 05/07/15	K.O.P.					7 ✓ 60																										
	Zoloft 150mg po qam + 120d Prescriber Eliason Order Date 12-10-14 Start Date 12-10-14 Stop Date 4-10-15																																
	Prescriber Order Date Start Date Stop Date																																
	Prescriber Order Date Start Date Stop Date																																

[redacted]

Diagnosis: No Known Drug Allergy

94691 6340- MAIN() **EDMO, MASON** 2/2

Allergies: DOB/Inmate #: Location: Name:

PharmaCorr

#5150 REV 4/10

ER 2068

Medication Administration Record

Documentation Codes	Staff Signature	Date	Initials	Staff Signature	Date	Initials
~~C. Ahearn, RN~~			L. Green, RN			K. Murray, RN
K. Barney, LPN			~~T. Tran, LPN~~			A. Nisby, LPN
D/C - Discontinued ~~A. Beaton, LPN~~			S. Harrod, MA			S. Patterson, LPN
A. Beshears, RN			L. Hill, PhT			S. Perus, LPN
R - Refused ~~S. Blackburn, LPN~~			~~A. Huddleston, CNA~~			H. Pierce, LPN
A - Absent C. Brenenstahl, dialysis tech			K. Hyatt, LPN			J. Prudhomme, LPN
G. Brewer, RN			~~D. Jensen, LPN~~			D. Rainier, LPN
O - Other L. Brown, LPN			S. Kelly, RMA			C. Read, LPN
~~M. Bryant, RN~~			~~S. Kitto, RN~~			E. Reed, LPN
G. Capshaw, RN			K. Larsen, LPN			G. Rodriguez, LPN
~~L. Carlson, RN, DON~~			T. Lee, RN			J. Savell, LPN
T. Case, LPN			D. Luna, LPN			F. Valenzuela, RN
P. Cleveland, MA			S. Mallet, LPN			C. Wilcox CNA
~~A. Cooley, LPN~~			C. Marria, LPN			C. Wilson, LPN
R. Daugherty, LPN			T. Mccall, LPN			~~W. Wingo, RN, DON~~
J. Drake, LPN			~~L. Moser CNA~~			C. Young, LPN
V. Ferro, LPN						A. Thurber, LPN
G. CATHERMAN LPN						D. Walthall RN

Date/Time	NOTES
12/7 AM	Absent PC
12/13/14 AM - Absent for PC-LM	
12/14/14 AM - Absent for PC-LM	
12/24/14 AM - Absent for PC-LM	
12/25/14 AM - Absent for PC-LM	

ER 2069

Pg:288
Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID **Month:** January 2015

Drug - Dose - Mode - Interval	HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
ASPIRIN EC 81 MG TBEC ~ECOTRIN~ #30 TAKE 1 TAB BY MOUTH DAILY FOR 210 DAYS>> DO NOT CRUSH << 12/13 Prescriber WHINNERY,CATHERINE Rx#31098135 Order Date 07/03/14 Start Date 7/8/14 Stop Date 02/02/15	K O P																		New Order													
CALCIUM CARB 1250MG/VIT D 1250 MG TABS ~OSCAL-D 500~ #30 TAKE 1 TAB BY MOUTH DAILY FOR 210 DAYS 12/13 Prescriber WHINNERY,CATHERINE Rx#31098161 Order Date 07/03/14 Start Date 7/4/14 Stop Date 01/29/15	K O P																			New Order											Stop	
CALCIUM POLYCARB (60/BOX) 625 MG TABS ~FIBER-LAX~ 11/20 TAKE 1 TAB BY MOUTH EVERY DAY FOR 180 DAYS TAKE WITH GLASS OF WATER #1 Prescriber GELOK,CHRISTIAN,NP Rx#31403082 Order Date 08/22/14 Start Date 8/23/14 Stop Date 02/18/15	K O P																															
ESTRADIOL 1 MG TABS ~ESTRACE~ #90 12/6 TAKE 3 TABS (3MG) BY MOUTH DAILY FOR 90 DAYS **APPROVED** (NOTE START DATE) Prescriber WHINNERY,CATHERINE Rx#31737713 Order Date 10/31/14 Start Date 10/31/14 Stop Date 01/29/15	K O P		1		90 V			Edmo #90 1/5/15 [illegible]																							Stop	
FINASTERIDE 5 MG TABS ~PROSCAR~ #30 12/6 TAKE 1 TAB BY MOUTH DAILY FOR 90 DAYS **APPROVED** >>WOMEN OF CHILD BEARING AGE SHOULD NOT HANDLE THIS DRUG<< Prescriber WHINNERY,CATHERINE Rx#31737719 Order Date 10/08/14 Start Date 10/9/14 Stop Date 01/06/15	K O P							Stop					New Order																			
Finasteride 5mg 5 mg PO Q Daily x90 days Prescriber Whinnery Order Date 1/8/15 Start Date 1-14-15 Stop Date 4-14-15	K O P														30 V									^					1			

[redacted]

94691 6340- MAIN(00) **EDMO, MASON** 1/2

DOB/Inmate #: Location: Name:

Diagnosis:
No Known Drug Allergy

Allergies:

#3150 REV 4/10 **PharmaCorr**

Medication Administration Record

Documentation Codes	Staff Signature	Date	Initials	Staff Signature	Date	Initials
	Sheela Parsons, LPN		SP	Guadalupe Rodriguez, LPN		R
D/C - Discontinued Order	Sheila Harrod			RMA	1/15	SH
R - Refused	Maria Gonzalez LPN MG					
A - Absent	P. Cleveland	12/27	PC			
O - Other	L. Mosier, CNA	1/15	LM			
	Amber Huddleston, C.N.A.	1/15	AH			
	Lori Hill, Pharmacy Tech	1-15	L			
	TC RN LPN	1/15	TC			

Date/Time	NOTES

ER 2071

MEDICATION ADMINISTRATION RECORD

Facility: ISCI **Month:** Jan 2015

Init.	Drug - Dose - Mode - Interval	HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	Zoloft 150mg PO qhs Prescriber Scott Eliason, MD Order Date 1/28 Start Date 1/28 Stop Date 5/28	P																													30 ✓		
	Prescriber Order Date Start Date Stop Date																																
	Prescriber Order Date Start Date Stop Date																																
	Prescriber Order Date Start Date Stop Date																																
	Prescriber Order Date Start Date Stop Date																																
	Prescriber Order Date Start Date Stop Date																																

Diagnosis:

Allergies: nka DOB/Inmate #: [redacted] 94691 Location: Name: Edmo, Mason

#3150 REV 4/10

Pg:289
Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID **Month:** January 2015

Init.	Drug - Dose - Mode - Interval	HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	SERTRALINE HCL 50 MG TABS ~ZOLOFT~ TAKE 3 TABS (150MG) BY MOUTH EACH MORNING FOR 120 DAYS >> MAY CAUSE DROWSINESS << Prescriber ELIASON,SCOTT PSY Rx#32083072 Order Date 12/10/14 Start Date 12/10/14 Stop Date 04/09/15	AM																											NEW ORDER			
	SPIRONOLACTONE 50 MG TABS ~ALDACTONE~ TAKE 1 TAB BY MOUTH TWICE DAILY FOR 210 DAYS >> MAY CAUSE DIZZINESS << Prescriber WHINNERY,CATHERINE Rx#31707371 Order Date 10/09/14 Start Date 10/9/14 Stop Date 05/07/15	K O P																														
	Spironolactone 100mg 100 mg po BID x210 days Prescriber Whinnery Order Date 1/8/15 Start Date 1/8/15 Stop Date 8/8/15	K O P																														
	Aspirin 81 mg 81 mg tab po QD Prescriber Whinnery Order Date 1/8/15 Start Date 1/8/15 Stop Date 8/8/15	K O P																														
	Calcium Carb ~Oscal D~ 500mg po QD Prescriber Whinnery Order Date 1/8/15 Start Date 1/8/15 Stop Date 8/8/15	K O P																														
	Estradiol 3mg po QD x90 days Prescriber Whinnery Order Date 1/8/15 Start Date 1/29/15 Stop Date 4/29/15	K O P																														

94691 6340- MAIN(00) **EDMO, MASON**

Diagnosis:
No Known Drug Allergy

Allergies: DOB/Inmate #: Location: Name:

PharmaCorr

#3150 REV 4/10

2/2

ER 2073

Medication Administration Record

Documentation Codes	Staff Signature	Date	Initials	Staff Signature	Date	Initials
	Sheela Parque, LPN		SP	Guadalupe Rodriguez, LPN		D
D/C - Discontinued Order	Sheila Heard-SH			[illegible] RMA	1/15	[illegible]
R - Refused	Maria Gonzalez LPN MG					
A - Absent	P. Cleveland	12/27	PC			
O - Other	L. Mosen, CNA	1/15	LM			
	Amber Huddleston, C.N.A.	1/15	AH			
	Lori Hill, Pharmacy Tech	1-15	L			
	D. Jensen	1-15	DJ			
	[illegible]	1/15	TC			

Date/Time		NOTES
1/3	AM	absent PC
1/4	AM	absent PC
8/15 AM - Absent - LM		
1-15-15	AM	ABSENT - ab
1-16-15	AM	Absent for pill pass DJ
1-17-15	AM	Absent for Pill pass Provider Notified [illegible]
1-18	AM	Absent Pill Pass [illegible]
1-19	AM	Absent Pill pass [illegible]
1-22-15	AM	"
1-23-15	AM	Absent for pill pass [illegible]
1-24-15	AM	" [illegible]

Pg:281
Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID **Month:** February 2015

Init.	Drug - Dose - Mode - Interval	HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	SERTRALINE HCL 50 MG TABS ~ZOLOFT~ TAKE 3 TABS (150MG) BY MOUTH EACH MORNING FOR 120 DAYS >> MAY CAUSE DROWSINESS << Prescriber ELIASON,SCOTT PSY Rx#32083072 Order Date 12/10/14 Start Date 12/10/14 Stop Date 04/09/15	AM		Dr. Eliason NEW ORDER																													
	SPIRONOLACTONE 100 MG TABS ~ALDACTONE~ 1/10 TAKE 1 TAB BY MOUTH TWICE DAILY FOR 210 DAYS >> MAY CAUSE DIZZINESS << #60 Prescriber WHINNERY,CATHERINE Rx#32241741 Order Date 01/09/15 Start Date 1/9/15 Stop Date 08/07/15												#32																				
	Prescriber Order Date Start Date Stop Date																																
	Prescriber Order Date Start Date Stop Date																																
	Prescriber Order Date Start Date Stop Date																																
	Prescriber Order Date Start Date Stop Date																																

Diagnosis:
No Known Drug Allergy

Allergies:

[redacted]

DOB/Inmate #: 94691 Location: 6340- MAIN(00) A-9 Name: EDMO, MASON

PharmaCorr

#3150 REV 4/10

Medication Administration Record

Documentation Codes	Staff Signature	Date	Initials	Staff Signature	Date	Initials
~~C. Ahearn, RN~~		M. Gonzales, LPN			~~K. Murray, RN~~	
K. Barney, LPN		M. Grace, RN			A. Nisby, LPN	
D/C - Discontinued Order ~~A. Benton, LPN~~		L. Green, RN			S. Patterson, LPN	
R - Refused A. Beshears, RN		T. Hall, LPN			S. Perus, LPN	
~~C. Blackburn, LPN~~		S. Harrod, MA			H. Pierce, LPN	
A - Absent C. Brenenstahl, dialysis tech		L. Hill, PhT			~~J. Prudhomme, LPN~~	
G. Brewer, RN		A. Huddleston, C N A			D. Rainier, LPN	
O - Other L. Brown, LPN		K. Hyatt, LPN			~~C. Read, LPN~~	
M. Bryant, RN		D. Jensen, LPN			E. Reed, LPN	
G. Capshaw, RN		S. Kelly, RMA			G. Rodriguez, LPN	
L. Carlson, RN, DON		~~S. Kitto, RN~~			J. Savell, LPN	
T. Case, LPN		K. Larsen, LPN			A. Thurber, LPN	
G. Catherman, LPN		T. Lee, RN			F. Valenzuela, RN	
P. Cleveland, MA		D. Luna, LPN			~~D. Walthall, RN~~	
A. Cooley, LPN		S. Mallet, LPN			C. Wilcox C N A	
R. Daugherty, LPN		C. Marria, LPN			C. Wilson, LPN	
J. Drake, LPN		T. Mccall, LPN			W. Wingert, RN, DON	
V. Ferro, LPN		L. Moser, C N A			C. Young, LPN	
					N. Smith RMA	
Date/Time		NOTES				

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID **Month:** February 2015

Init.	Drug - Dose - Mode - Interval	HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	ASPIRIN EC 81 MG TBEC ~ECOTRIN ~ #30 1/10 TAKE 1 TAB BY MOUTH DAILY FOR 210 DAYS >> DO NOT CRUSH << Prescriber WHINNERY,CATHERINE Rx#32241743 Order Date 01/09/15 Start Date 1/9/15 Stop Date 08/07/15			V 30	13 #30 LM														K O P									A					
	CALCIUM CARB 1250MG/VIT D 1250 MG TABS ~OSCAL-D 500~ #30 1/10 TAKE 1 TAB BY MOUTH DAILY FOR 210 DAYS Prescriber WHINNERY,CATHERINE Rx#32241747 Order Date 01/09/15 Start Date 1/9/15 Stop Date 08/07/15				13 #30 LM														K O P									A					
	CALCIUM POLYCARB (60/BOX) 625 MG TABS ~FIBER-LAX~ TAKE 1 TAB BY MOUTH EVERY DAY FOR 180 DAYS TAKE WITH GLASS OF WATER Prescriber GELOK,CHRISTIAN,NP Rx#31403082 Order Date 08/22/14 Start Date 9/23/14 Stop Date 02/18/15			V 30															K O P				D/C 2/19 Per Geldt										
	ESTRADIOL 1 MG TABS ~ESTRACE~ #90 1/21 TAKE 3 TABS BY MOUTH DAILY FOR 90 DAYS **APPROVED** Prescriber WHINNERY,CATHERINE Rx#32267138 Order Date 01/29/15 Start Date 1/29/15 Stop Date 04/29/15															V 90			K O P														
	FINASTERIDE 5 MG TABS ~PROSCAR~ AKE 1 TAB BY MOUTH DAILY FOR 90 DAYS **APPROVED** >>WOMEN OF CHILD BEARING AGE SHOULD NOT HANDLE THIS DRUG<< Prescriber WHINNERY,CATHERINE Rx#32267145 Order Date 01/13/15 Start Date 1/14/15 Stop Date 04/13/15				V 30 (bag)														K O P														
	Zoloft 150mg PO qhs #120d Prescriber Dr. Eliason Order Date 4/8 Start Date 4/8 Stop Date 5/28																										V 90						

[redacted] 94691 6340- MAIN(00) EDMO, MASON A-9

Diagnosis: No Known Drug Allergy

Allergies: DOB/Inmate #: Location: Name:

PharmaCorr

#3150 REV 4/10

ER 2077

Medication Administration Record

Documentation Codes

D/C - Discontinued Order
R - Refused
A - Absent
O - Other

Staff Signature	Date	Staff Signature	Date	Staff Signature	Date
~~C. Ahearn, RN~~	2-2015	M. Gonzales, LPN	2-2015	~~K. Murray, RN~~	2-2015
K. Barney, LPN	2-2015	M. Grace, RN	2-2015	A. Nisby, LPN	2-2015
A. Benton, LPN	2-2015	L. Green, RN	2-2015	S. Patterson, LPN	2-2015
A. Beshears, RN	2-2015	T. Hall, LPN	2-2015	S. Perus, LPN	2-2015
~~G. Blackburn, LPN~~	2-2015	~~S. Harrod, MA~~	2-2015	H. Pierce, LPN	2-2015
C. Brenenstahl, dialysis tech	2-2015	L. Hill, PhT	2-2015	~~J. Prudhomme, LPN~~	2-2015
G. Brewer, RN	2-2015	A. Huddleston, C N A	2-2015	D. Rainier, LPN	2-2015
~~L. Brown, LPN~~	2-2015	K. Hyatt, LPN	2-2015	~~C. Reed, LPN~~	2-2015
M. Bryant, RN	2-2015	D. Jensen, LPN	2-2015	E. Reed, LPN	2-2015
G. Capshaw, RN	2-2015	S. Kelly, RMA	2-2015	G. Rodriguez, LPN	2-2015
L. Carlson, RN, DON	2-2015	~~S. Kitto, RN~~	2-2015	J. Savell, LPN	2-2015
T. Case, LPN	2-2015	K. Larsen, LPN	2-2015	A. Thurber, LPN	2-2015
~~G. Catherman, LPN~~	2-2015	~~T. Lee, RN~~	2-2015	F. Valenzuela, RN	2-2015
P. Cleveland, MA	2-2015	D. Luna, LPN	2-2015	~~D. Walthall, RN~~	2-2015
A. Cooley, LPN	2-2015	S. Mallet, LPN	2-2015	C. Wilcox C N A	2-2015
~~R. Daugherty, LPN~~	2-2015	~~C. Marria, LPN~~	2-2015	C. Wilcon, LPN	2-2015
J. Drake, LPN	2-2015	T. Mccall, LPN	2-2015	W. Wingert, RN, DON	2-2015
V. Ferro, LPN	2-2015	L. Moser, C N A	2-2015	C. Young, LPN	2-2015
	2-2015		2-2015	A. Smith RMA	2-2015
	2-2015		2-2015		2-2015
	2-2015		2-2015		2-2015

Date/Time	NOTES
2-4-15 Pm	[illegible]
2-5-15 Pm	[illegible]
2/11 R	[illegible]
2/12 R	[illegible]
2/13 R	[illegible] - provider notified
2/14 R	[illegible]
2/15/15 PM	Refused fiberlax
2/25/15 am	Absent
2-27 1000	absent [illegible]
2/28/15 pm	Absent

Medication Administration Record

Documentation Codes	Staff Signature	Date	Initials
~~C. Ahearn, RN~~			
K. Barney, LPN			
~~A. Benton, LPN~~			
A. Beshears, RN			
~~C. Blackburn, LPN~~			
C. Brenenstahl, dialysis tech			
G. Brewer, RN			
L. Brown, LPN			
M. Bryant, RN			
~~G. Capshaw, RN~~			
L. Carlson, RN, DON			
T. Case, LPN			
~~G. Catherman, LPN~~			
P. Cleveland, MA			
A. Cooley, LPN			
~~R. Daugherty, LPN~~			
J. Drake, LPN			
V. Ferro, LPN			

D/C - Discontinued Order

R - Refused

A - Absent

O - Other

Staff Signature	Date	Initials
M. Gonzales, LPN		
M. Grace, RN		
~~L. Green, RN~~		
T. Hall, LPN		
~~S. Harrod, MA~~		
L. Hill, PhT		
A. Huddleston, C N A		
K. Hyatt, LPN		
D. Jensen, LPN		
S. Kelly, CMA		
~~S. Kitto, RN~~		
K. Larsen, LPN		
~~T. Lee, RN~~		
D. Luna, LPN		
S. Mallet, LPN		
~~C. Marria, LPN~~		
T. Mccall, LPN		
L. Moser, C N A		

Staff Signature	Date	Initials
~~K. Murray, RN~~		
A. Nisby, LPN		
S. Patterson, LPN		
S. Perus, LPN		
H. Pierce, LPN		
~~J. Prudhomme, LPN~~		
D. Rainier, LPN		
~~C. Read, LPN~~		
E. Reed, LPN		
G. Rodriguez, LPN		
J. Savell, LPN		
A. Thurber, LPN		
F. Valenzuela, RN		
~~D. Walthall, RN~~		
C. Wilcox C N A		
~~C. Wilson, LPN~~		
W. Wingert, RN, DON		
C. Young, LPN		
M. Smith RMA		

Date/Time	NOTES
2-27-15 1000	absent for Kot

ER 2079

Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID **Month:** March 2015

Init.	Drug - Dose - Mode - Interval	HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
SH	**ASPIRIN EC 81 MG TBEC ~ECOTRIN ~** 22 #30 TAKE 1 TAB BY MOUTH DAILY FOR 210 DAYS >> DO NOT CRUSH << Prescriber WHINNERY,CATHERINE Rx#32241743 Order Date 01/09/15 Start Date 1/9/15 Stop Date 08/07/15	K O P							Inm Sign: EDMO DATE: 3/3 # Disp: 30 Staff: E																		30 V					A
SH	**CALCIUM CARB 1250MG/VIT D 1250 MG TABS ~OSCAL-D 500~** 2.3 #30 TAKE 1 TAB BY MOUTH DAILY FOR 210 DAYS Prescriber WHINNERY,CATHERINE Rx#32241747 Order Date 01/09/15 Start Date Stop Date 08/07/15	K O P									Inm Sign: EDMO DATE: 3/3 # Disp: 30 Staff: E															30 V					A
SH	**ESTRADIOL 1 MG TABS ~ESTRACE~** 2.14 #90 TAKE 3 TABS BY MOUTH DAILY FOR 90 DAYS **APPROVED** Prescriber WHINNERY,CATHERINE Rx#32267138 Order Date 01/29/15 Start Date 1.29 Stop Date 04/29/15	K O P									Inm Sign: EDMO DATE: # Disp: Staff:									1 90 V Inm Sign: EDMO DATE: 3-23 # Disp: 90 Staff: RAC										
SH	**FINASTERIDE 5 MG TABS ~PROSCAR~** 2.5 #30 TAKE 1 TAB BY MOUTH DAILY FOR 90 DAYS **APPROVED** >>WOMEN OF CHILD BEARING AGE SHOULD NOT HANDLE THIS DRUG<< Prescriber WHINNERY,CATHERINE Rx#32267145 Order Date 01/13/15 Start Date 1.14 Stop Date 04/13/15	K O P									Inm Sign: EDMO DATE: 3-23 # Disp: 30 Staff: E																					30
SH	**SERTRALINE HCL 50 MG TABS ~ZOLOFT~** TAKE TABS BY MOUTH AT BEDTIME FOR 120 DAYS >> MAY CAUSE DROWSINESS << Prescriber ELIASON,SCOTT PSY Rx#32356584 Order Date 01/28/15 Start Date 1/28 Stop Date 05/28/15	HS	A																														
	Prescriber Order Date Start Date Stop Date																																

Diagnosis: No Known Drug Allergy

Allergies:

94691 DOB/Inmate #:

6340- MAIN(00) Location:

EDMO, MASON Name:

1/2

PharmaCorr

#3150 REV 4/10

ER 2080

ER 2081

Medication Administration Record

Documentation Codes	Staff Signature	Date	Initials	Staff Signature	Date	Initials
D/C - Discontinued Order	~~C. Ahearn, RN~~	~~M. Gonzales, LPN~~		~~N. Murray, RN~~		
R - Refused	K. Barney, LPN	~~M. Grace, RN~~		~~A. Nisby, LPN~~		
A - Absent	~~A. Benton, LPN~~	L. Green, RN		S. Patterson, LPN		
O - Other	A. Beshears, RN	~~T. Hall, LPN~~		S. Perus, LPN		
	G. Blackburn, LPN	S. Harrod, MA		H. Pierce, LPN		
	C. Brenenstahl, dialysis tech	L. Hill, PhT		~~J. Prudhomme, LPN~~		
	G. Brewer, RN	A. Huddleston, C N A		D. Rainier, LPN		
	L. Brown, LPN	K. Hyatt, LPN		~~E. Read, LPN~~		
	~~M. Bryant, RN~~	D. Jensen, LPN		E. Reed, LPN		
	G. Capshaw, RN	S. Kelly, RMA		G. Rodriguez, LPN		
	L. Carlson, RN, DON	S. Kitto, RN		J. Savell, LPN		
	T. Case, LPN	K. Larsen, LPN		~~A. Smith, RMA~~		
	~~G. Catherman, LPN~~	T. Lee, RN		~~K. Thurber, LPN~~		
	P. Cleveland, MA	D. Luna, LPN		F. Valenzuela, RN		
	A. Cooley, LPN	S. Mallet, LPN		~~D. Walthall, RN~~		
	R. Daugherty, LPN	C. Marria, LPN		C. Wilcox C N A		
	J. Drake, LPN	T. Mccall, LPN		C. Wilson, LPN		
	V. Ferro, LPN	L. Moser, C N A		~~W. Wingert, RN, DON~~		
	Mardy Bock RN			C. Young, LPN		
Date/Time	Janell Allen RN		NOTES			
3/14/15	8	Absent				
3-30-15	1408	absent				

Medication Administration Record

Documentation Codes

- D/C - Discontinue
- R - Refused
- A - Absent
- O - Other

Staff Signature	Date	Staff Signature	Date	Staff Signature	Date
~~C. Ahearn, RN~~	3-2015	~~M. Gonzales, LPN~~	3-2015	~~K. Murray, RN~~	3-2015
K. Barney, LPN	3-2015	~~M. Grace, RN~~	3-2015	~~A. Nisby, LPN~~	3-2015
~~Benton, LPN~~	3-2015	L. Green, RN	3-2015	S. Patterson, LPN	3-2015
A. Beshears, RN	3-2015	~~T. Hall, LPN~~	3-2015	S. Perus, LPN	3-2015
G. Blackburn, LPN	3-2015	S. Harrod, MA	3-2015	H. Pierce, LPN	3-2015
C. Brenenstahl, dialysis tech	3-2015	L. Hill, PhT	3-2015	~~J. Prudhomme, LPN~~	3-2015
G. Brewer, RN	3-2015	A. Huddleston, C N A	3-2015	D. Rainier, LPN	3-2015
~~L. Brown, LPN~~	3-2-15	K. Hyatt, LPN	3-2015	~~C. Read, LPN~~	3-2015
~~M. Bryant, RN~~	3-2015	D. Jensen, LPN	3-2015	E. Reed, LPN	3-2015
G. Capshaw, RN	3-2015	S. Kelly, RMA	3-2015	G. Rodriguez, LPN	3-2015
L. Carlson, RN, DON	3-2015	S. Kitto, RN	3-2015	J. Savell, LPN	3-2015
T. Case, LPN	3-2015	K. Larsen, LPN	3-2015	~~A. Smith, RMA~~	3-2015
G. Catherman, LPN	3-2015	T. Lee, RN	3-2015	~~R. Thurber, LPN~~	3-2015
P. Cleveland, MA	3-2015	D. Luna, LPN	3-2015	F. Valenzuela, RN	3-2015
A. Cooley, LPN	3-2015	S. Mallet, LPN	3-2015	~~D. Walthall, RN~~	3-2015
R. Daugherty, LPN	3-2015	C. Marria, LPN	3-2015	C. Wilcox C N A	3-2015
J. Drake, LPN	3-2015	T. Mccall, LPN	3-2015	C. Wilson, LPN	3-2015
V. Ferro, LPN	3-2015	L. Moser, C N A	3-2015	~~W. Wingert, RN, DON~~	3-2015
Mardy Bock RN	3-2015		3-2015	C. Young, LPN	3-2015
Janell Allen RN	3-2015		3-2015		3-2015
	3-2015		3-2015		3-2015

Date/Time	NOTES
3-1-15 pm Absent for pill pass	
3-2-15 pm absent for pill pass	
3-3-15 pm Absent for pill pass Provider notified	
3-4-15 pm Absent for pill pass	
3-5-15 pm Absent for pill pass	
3/6/15 pm Absent Provider Notified	
3/7/15 pm Absent	
3/8/15 pm	absent for pills ~~absent~~
3/9/15 pm	absent for pills absent Provider Notified
3.30.15 KCP	absent

Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID **Month:** March 2015

Init.	Drug - Dose - Mode - Interval	HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	SPIRONOLACTONE 100 MG TABS ~ALDACTONE~ 2.2 #60 TAKE 1 TAB BY MOUTH TWICE DAILY FOR 210 DAYS >> MAY CAUSE DIZZINESS << Prescriber WHINNERY,CATHERINE Rx#32241741 Order Date 01/09/15 Start Date 1/9 Stop Date 08/07/15	K O P					Inm Sign: [signature] DATE: 3/3 # Disp: 60 Staff: [signature]																												
	Effexor 37.5mg PO qAM x7d Prescriber Jeremy Stoddart, MD Order Date 3/10 Start Date 3/11 Stop Date 3/17																																
	Effexor 75mg PO qAM x120 days Prescriber Jeremy Stoddart, MD Order Date 3/10 Start Date 3/18 Stop Date 7/16																																
	Prescriber Order Date Start Date Stop Date																																
	Prescriber Order Date Start Date Stop Date																																
	Prescriber Order Date Start Date Stop Date																																

Diagnosis: No Known Drug Allergy
Allergies:

[redacted] 94691 DOB/Inmate #:

6340- MAIN(00) Location:

EDMO, MASON 2/2 Name:

PharmaCorr

#3150 REV 4/10

ER 2083

ER 2084

Medication Administration Record

Documentation Codes	Staff Signature	Initials	Date
D/C - Discontinued Order	~~C. Ahearn, RN~~		3-2015
R - Refused	~~J. Allen, RN~~		3-2015
A - Absent	K. Barney, LPN	KB	3-2015
O - Other	~~M. Beck, RN~~		3-2015
	~~A. Benton, LPN~~		3-2015
	A. Beshears, RN	AB	3-2015
	~~C. Blackburn, LPN~~		3-2015
	C. Brenenstahl, dialysis tech		3-2015
	G. Brewer, RN		3-2015
	L. Brown, LPN	LB	3-2015
	~~M. Bryant, RN~~		3-2015
	G. Capshaw, RN		3-2015
	L. Carlson, RN, DON		3-2015
	T. Case, LPN	TC	3-2015
	~~S. Catherman, LPN~~		3-2015
	P. Cleveland, MA		3-2015
	A. Cooley, LPN	AC	3-2015
	~~B. Daugherty, LPN~~		3-2015
	J. Drake, LPN		3-2015
	V. Ferro, LPN		3-2015
	M. Gonzalez, LPN		3-2015
	~~M. Grace, RN~~		3-2015
	L. Green, RN		3-2015
	~~T. Hall, LPN~~		3-2015
	S. Harrod, MA		3-2015
	L. Hill, PhT		3-2015
	A. Huddleston, C N A		3-2015
	~~K. Hyatt, LPN~~		3-2015
	~~D. Jensen, LPN~~		3-2015
	~~S. Kelly, RMA~~		3-2015
	~~S. Kitts, RN~~		3-2015
	K. Larsen, LPN	KL	3-2015
	~~T. Lee, RN~~		3-2015
	D. Luna, LPN		3-2015
	~~S. Mallet, LPN~~		3-2015
	C. Marria, LPN		3-2015
	T. Mccall, LPN		3-2015
	L. Moser, C N A	LM	3-2015
	~~K. Murray, RN~~		3-2015
	A. Nisby, LPN		3-2015
	~~S. Patterson, LPN~~		3-2015
	S. Perus, LPN		3-2015
	H. Pierce, LPN		3-2015
	~~J. Prudhomme, LPN~~		3-2015
	D. Rainier, LPN		3-2015
	C. Read, LPN		3-2015
	E. Reed, LPN		3-2015
	G. Rodriguez, LPN		3-2015
	J. Savell, LPN		3-2015
	~~A. Smith, RMA~~		3-2015
	~~A. Thurber, LPN~~		3-2015
	F. Valenzuela, RN		3-2015
	~~D. Walthall, RN~~		3-2015
	C. Wilcox C N A		3-2015
	C. Wilson, LPN		3-2015
	W. Wingert, RN, DON		3-2015
	C. Young, LPN		3-2015

Date/Time		
	~~April Smith, RMA~~	
4-1-15	AM	Absent
4-3-15	AM	Absent
4-7-15	AM	absent SH
4-8	AM	Absent
4-11-15	AM	absent SH
4-16-15	AM	Absent for pill pass
4-17-15	AM	absent
4-18-15	AM	absent SH

NOTES

Medication Administration Record

Documentation Codes	Staff Signature	Date	Initials	Staff Signature	Date	Initials
D/C - Discontinued Order	~~C. Ahearn, RN~~		M. Gonzalez, LPN		~~K. Murray, RN~~	
R - Refused	~~J. Allen, RN~~		~~M. Grace, RN~~		A. Nisby, LPN	
A - Absent	K. Barney, LPN		L. Green, RN		~~S. Patterson, LPN~~	
O - Other	~~M. Beck, RN~~		~~T. Hall, LPN~~		S. Perus, LPN	
	~~A. Benton, LPN~~		S. Harrod, MA		H. Pierce, LPN	
	A. Beshears, RN		L. Hill, PhT		~~J. Prudhomme, LPN~~	
	~~C. Blackburn, LPN~~		A. Huddleston, C N A		D. Rainier, LPN	
	C. Brenenstahl, dialysis tech		~~K. Hyatt, LPN~~		C. Read, LPN	
	G. Brewer, RN		~~D. Jensen, LPN~~		E. Reed, LPN	
	L. Brown, LPN		~~S. Kelly, RMA~~		G. Rodriguez, LPN	
	~~M. Bryant, RN~~		~~S. Kitko, RN~~		J. Savell, LPN	
	G. Capshaw, RN		K. Larsen, LPN		~~A. Smith, RMA~~	
	L. Carlson, RN, DON		~~T. Lee, RN~~		~~A. Thurber, LPN~~	
	T. Case, LPN		D. Luna, LPN		F. Valenzuela, RN	
	~~C. Catherman, LPN~~		~~S. Mallet, LPN~~		~~D. Walthall, RN~~	
	P. Cleveland, MA		C. Marria, LPN		C. Wilcox C N A	
	A. Cooley, LPN		T. Mccall, LPN		C. Wilson, LPN	
	~~B. Daugherty, LPN~~		L. Moser, C N A		W. Wingert, RN, DON	
	J. Drake, LPN				C. Young, LPN	
Date/Time	V. Ferro, LPN		NOTES			
	April Smith, RMA					

ER 2085

Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID **Month:** April 2015

Init. | Drug - Dose - Mode - Interval | HR | 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

ASPIRIN EC 81 MG TBEC ~ECOTRIN ~ 3.2 #30
TAKE 1 TAB BY MOUTH DAILY FOR 210 DAYS >> DO NOT CRUSH <<
Prescriber WHINNERY,CATHERINE Rx#32241743
Order Date 01/09/15 Start Date 1.9 Stop Date 08/07/15
HR: AM K.O.P.

CALCIUM CARB 1250MG/VIT D 1250 MG TABS ~OSCAL-D 500~ 3.2 #30
TAKE 1 TAB BY MOUTH DAILY FOR 210 DAYS
Prescriber WHINNERY,CATHERINE Rx#32241747
Order Date 01/09/15 Start Date 1.9 Stop Date 08/07/15
HR: AM K.O.P.

ESTRADIOL 1 MG TABS ~ESTRACE~ 3.21 #90
TAKE 3 TABS BY MOUTH DAILY FOR 90 DAYS **APPROVED**
Prescriber WHINNERY,CATHERINE Rx#32267138
Order Date 01/29/15 Start Date 1.29 Stop Date 04/29/15
HR: K.O.P.

FINASTERIDE 5 MG TABS ~PROSCAR~ 3.16 #30
TAKE 1 TAB BY MOUTH DAILY FOR 90 DAYS **APPROVED** >>WOMEN OF CHILD BEARING AGE SHOULD NOT HANDLE THIS DRUG<<
Prescriber WHINNERY,CATHERINE Rx#32267145
Order Date 01/13/15 Start Date 1.14 Stop Date 04/13/15
HR: K.O.P.

SPIRONOLACTONE 100 MG TABS ~ALDACTONE~ 3.2 #60
TAKE 1 TAB BY MOUTH TWICE DAILY FOR 210 DAYS >> MAY CAUSE DIZZINESS <<
Prescriber WHINNERY,CATHERINE Rx#32241741
Order Date 01/09/15 Start Date 1.9 Stop Date 08/07/15
HR: AM K.O.P.

finasteride 5mg tabs ~ Proscar ~
PO. Q day x90days
Prescriber Whinnery
Order Date 4/6/15 Start Date 4/15/15 Stop Date 7/15/15
HR: K.O.P.

Diagnosis: No Known Drug Allergy
Allergies:

[redacted] 94691 6340- MAIN(00) **EDMO, MASON** 1/2
DOB/Inmate #: Location:

PharmaCorr
#3150 REV 4/10

A.4

ER 2086

Pg:2/6
Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID **Month:** April 2015

Init. | Drug - Dose - Mode - Interval | HR 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

VENLAFAXINE HCL 75 MG TABS ~EFFEXOR~

TAKE 1 TAB BY MOUTH EACH MORNING FOR 120 DAYS (NOTE START DATE) >> TAKE WITH FOOD; MAY CAUSE DROWSINESS <<

Prescriber STODDART,JEREMY,MD Rx#32606029

Order Date 03/18/15 Start Date 3-18 Stop Date 07/16/15

Estradiol 1mg ~Estrace~
take 3 tabs P.O. Qday x 90days

Prescriber ~~Whitney~~ Poulson

Order Date 4/7/15 Start Date 4/8/15 Stop Date 7/8/15

Proscar 5mg PO Q day x 90 days *approved

Prescriber Poulson

Order Date 4.6.15 Start Date 4.9.15 Stop Date 7.9.15

Prescriber

Order Date Start Date Stop Date

Prescriber

Order Date Start Date Stop Date

Prescriber

Order Date Start Date Stop Date

Diagnosis: No Known Drug Allergy

Allergies:

[redacted] 94691 DOB/Inmate #:

6340- MAIN(00) Location:

EDMO, MASON 2/2 Name:

PharmaCorr

#3150 REV 4/10

ER 2087

Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID **Month:** May 2015

Init.	Drug - Dose - Mode - Interval	HR	1–31
[illegible]	VENLAFAXINE HCL 75 MG TABS ~EFFEXOR~ TAKE 1 TAB BY MOUTH EACH MORNING FOR 120 DAYS (NOTE START DATE) >> TAKE WITH FOOD; MAY CAUSE DROWSINESS << crush Prescriber STODDART,JEREMY,MD Rx#32606029 Order Date 03/18/15 Start Date 3/18/15 Stop Date 07/16/15	AM	[handwritten initials, days 1–27] New order
[illegible]	Effexor 75mg i po q AM x 120 days CRUSH Prescriber Seys Order Date 4·30 Start Date 4·30 Stop Date 8·28	AM	→ [illegible]
	Prescriber Order Date Start Date Stop Date		
	Prescriber Order Date Start Date Stop Date		
	Prescriber Order Date Start Date Stop Date		
	Prescriber Order Date Start Date Stop Date		

[redacted]

Diagnosis:
No Known Drug Allergy

Allergies:

DOB/Inmate #: 94691 6340- Location: MAIN(00) [illegible] Name: EDMO, MASON

PharmaCorr

33950 REV 4/05

Medication Administration Record

Documentation Codes	Staff Signature	Initials	Date	Staff Signature	Initials	Date	Staff Signature	Initials	Date
	~~C. Ahearn, RN~~		5-2015	J. Drake, LPN		5-2015	A. Nisby, LPN		5-2015
	J. Allen, RN	SA	5-2015	V. Ferro, LPN		5-2015	~~S. Patterson, LPN~~		5-2015
D/C - Discontinued	~~K. Bachley~~, LPN		5-2015	M. Gonzalez, LPN		5-2015	S. Perus, LPN		5-2015
	M. Beck, RN		5-2015	M. Grace, RN		5-2015	H. Pierce, LPN		5-2015
R - Refused	~~A. Benton, LPN~~		5-2015	~~L. Green, RN~~		5-2015	~~P. Podhorniak, LPN~~		5-2015
A - Absent	A. Beshears, RN	AB	5-2015	S. Harrod, MA		5-2015	D. Rainier, LPN		5-2015
	G. Blackburn, LPN		5-2015	L. Hill, PhT		5-2015	C. Read, LPN		5-2015
O - Other	~~C. Brenenstahl, dialysis tech~~		5-2015	A. Huddleston, C N A		5-2015	E. Reed, LPN		5-2015
	G. Brewer, RN		5-2015	D. Jensen, LPN		5-2015	G. Rodriguez, LPN		5-2015
	~~L. Brown, LPN~~		5-2015	~~S. Kitto, RN~~		5-2015	~~J. Savell, LPN~~		5-2015
	M. Bryant, RN		5-2015	K. Larsen, LPN		5-2015	A. Smith, RMA		5-2015
	G. Capshaw, RN		5-2015	T. Lee, RN		5-2015	~~A. Therber, LPN~~		5-2015
	L. Carlson, RN, DON		5-2015	D. Luna, LPN		5-2015	F. Valenzuela, RN		5-2015
	T. Case, LPN	TC	5-2015	S. Mallet, LPN		5-2015	~~D. Walthall, RN~~		5-2015
	~~G. Cotherman, LPN~~		5-2015	C. Marria, LPN		5-2015	C. Wilcox C N A		5-2015
	P. Cleveland, MA		5-2015	T. Mccall, LPN		5-2015	C. Wilson, LPN		5-2015
	A. Cooley, LPN		5-2015	L. Moser, C N A		5-2015	W. Wingert, RN, DON		5-2015
	~~R. Daugherty, LPN~~		5-2015	K. Murray, RN		5-2015	C. Young, LPN		5-2015
			5-2015			5-2015			5-2015

Date/Time	NOTES
5.7 pm	Rosa Johnson, MA Absent
5/8/15 pm	Absent for pill pass

Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID **Month:** May 2015

Init.	Drug - Dose - Mode - Interval	HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	ASPIRIN EC 81 MG TBEC ~ECOTRIN~ TAKE 1 TAB BY MOUTH DAILY FOR 210 DAYS >> DO NOT CRUSH << Prescriber WHINNERY,CATHERINE Rx#32241743 Order Date 01/09/15 Start Date 1/9/15 Stop Date 08/07/15	am																															
	CALCIUM CARB 1250MG/VIT D 1250 MG TABS ~OSCAL-D 500~ TAKE 1 TAB BY MOUTH DAILY FOR 210 DAYS Prescriber WHINNERY,CATHERINE Rx#32241747 Order Date 01/09/15 Start Date 1/9/15 Stop Date 08/07/15	am																															
	ESTRADIOL 1 MG TABS ~ESTRACE~ TAKE 3 TABS (3MG) BY MOUTH DAILY FOR 90 DAYS **APPROVED** Prescriber POULSON,WILLIAM NP Rx#32795286 Order Date 04/09/15 Start Date 4/9/15 Stop Date 07/08/15	am																															
	FINASTERIDE 5 MG TABS ~PROSCAR~ TAKE 1 TAB BY MOUTH DAILY FOR 90 DAYS **APPROVED** >>WOMEN OF CHILD BEARING AGE SHOULD NOT HANDLE THIS DRUG<< Prescriber POULSON,WILLIAM NP Rx#32795290 Order Date 04/09/15 Start Date 4/9/15 Stop Date 07/08/15	am																															
	SPIRONOLACTONE 100 MG TABS ~ALDACTONE~ AKE 1 TAB BY MOUTH TWICE DAILY FOR 210 DAYS >> MAY CAUSE IZZINESS << Prescriber WHINNERY,CATHERINE Rx#32241741 Order Date 01/09/15 Start Date 1/9/15 Stop Date 08/07/15	am pm																															
	ABD Pad to be given 1x daily while in segregation Prescriber Order Date Start Date Stop Date	T 4 1																															

[redacted] 94691 6340- MAIN(00) **EDMO, MASON**

Diagnosis: No Known Drug Allergy

Allergies: DOB/Inmate #: Location: N4 Name:

#3150 REV 4/10

PharmaCorr

ER 2090

ER 2091

Medication Administration Record

Documentation Codes	Staff Signature	Date	Initials
	~~C. Ahearn, RN~~		
	J. Allen, RN		
D/C - Discon	~~K. Barney, LPN~~		
	M. Beck, RN		
R - Refused	A. Benton, LPN		
	A. Beshears, RN		
A - Absent	G. Blackburn, LPN		
	~~C. Brenenstahl, dialysis tech~~		
O - Other	G. Brewer, RN		
	~~L. Brown, LPN~~		
	M. Bryant, RN		
	G. Capshaw, RN		
	L. Carlson, RN, DON		
	T. Case, LPN		
	~~C. Catherman, LPN~~		
	P. Cleveland, MA		
	A. Cooley, LPN		
	~~M. Daugherty, LPN~~		

Staff Signature	Date	Initials
J. Drake, LPN	5-2015	
V. Ferro, LPN	5-2015	
M. Gonzalez, LPN	5-2015	
M. Grace, RN	5-2015	
L. Green, RN	5-2015	
S. Harrod, MA	5-2015	
L. Hill, PhT	5-2015	
A. Huddleston, C N A	5-2015	
D. Jensen, LPN	5-2015	
~~S. Kitto, RN~~	5-2015	
K. Larsen, LPN	5-2015	
T. Lee, RN	5-2015	
D. Luna, LPN	5-2015	
S. Mallet, LPN	5-2015	
C. Marria, LPN	5-2015	
T. Mccall, LPN	5-2015	
L. Moser, C N A	5-2015	
K. Murray, RN	5-2015	
	5-2015	

Staff Signature	Date	Initials
A. Nisby, LPN	4/	
~~S. Patterson, LPN~~		
S. Perus, LPN		
H. Pierce, LPN		
~~J. Pendleton, CMA~~		
D. Rainier, LPN		
C. Read, LPN		
E. Reed, LPN		
G. Rodriguez, LPN		
J. Savell, LPN		
A. Smith, RMA		
~~A. Thurber, LPN~~		
F. Valenzuela, RN		
~~D. Walthall, RN~~		
C. Wilcox C N A		
C. Wilson, LPN		
W. Wingert, RN, DON		
C. Young, LPN		
C. Curtis, LPN		

Date/Time	NOTES
Rosa Johnson, MA	
5-13-15 Am absent SH	

Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID **Month:** June 2015

Init.	Drug - Dose - Mode - Interval	HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
SH	**ASPIRIN EC 81 MG TBEC ~ECOTRIN ~** 3-11 30 reissued TAKE 1 TAB BY MOUTH DAILY FOR 210 DAYS >> DO NOT CRUSH << Prescriber WHINNERY,CATHERINE Rx#32241743 Order Date 01/09/15 Start Date 1-9 Stop Date 08/07/15	K.O.P.			✓ 30						Inm Sign: EDMO DATE: 6-8 # Disp: 30 Staff: 13																				New Order	
SH	**CALCIUM CARB 1250MG/VIT D 1250 MG TABS ~OSCAL-D 500~** 3-11 #16 reissued TAKE 1 TAB BY MOUTH DAILY FOR 210 DAYS Prescriber WHINNERY,CATHERINE Rx#32241747 Order Date 01/09/15 Start Date 1-9 Stop Date 08/07/15	K.O.P.							^		Inm Sign: DATE: # Disp: Staff:										30									New Order	
SH	**ESTRADIOL 1 MG TABS ~ESTRACE~** 3-11 90 reissued TAKE 3 TABS (3MG) BY MOUTH DAILY FOR 90 DAYS **APPROVED** Prescriber POULSON,WILLIAM NP Rx#32795286 Order Date 04/09/15 Start Date 4-9 Stop Date 07/08/15	K.O.P.			✓ 90						Inm Sign: EDMO DATE: 6-8 # Disp: #90 Staff: 13																					
SH	**FINASTERIDE 5 MG TABS ~PROSCAR~** 3-11 #30 reissued TAKE 1 TAB BY MOUTH DAILY FOR 90 DAYS **APPROVED** >>WOMEN OF CHILD BEARING AGE SHOULD NOT HANDLE THIS DRUG<< Prescriber POULSON,WILLIAM NP Rx#32795290 Order Date 04/09/15 Start Date 4-9 Stop Date 07/08/15	K.O.P.							^		Inm Sign: DATE: # Disp: Staff:																					
SH	**SPIRONOLACTONE 100 MG TABS ~ALDACTONE~** 3-11 39 reissued TAKE 1 TAB BY MOUTH TWICE DAILY FOR 210 DAYS >> MAY CAUSE DIZZINESS << Prescriber WHINNERY,CATHERINE Rx#32241741 Order Date 01/09/15 Start Date 1-9 Stop Date 08/07/15	K.O.P.							^		Inm Sign: DATE: # Disp: Staff:										60							A				
SH	ASA 81mg po Qday x 210days Prescriber Feder Order Date 6/2/16 Start Date 6/27 Stop Date 1/27/16	DCK																											✓ 3E				

[redacted]

94691 6340- MAIN(00) **EDMO, MASON** 1/2

Diagnosis: No Known Drug Allergy

Allergies: DOB/Inmate #: Location: Name:

PharmaCorr

#3150 REV 4/10

ER 2092

Medication Administration Record

Documentation Codes	Staff Signature
	~~C. Ahearn, RN~~
	~~J. Allen, RN~~
D/C - Discont	~~K. Bensley, LPN~~
	~~M. Beek, RN~~
R - Refused	A. Benton, LPN
	A. Beshears, RN
A - Absent	~~G. Blackburn, LPN~~
O - Other	C. Brenenstahl, dialysis tech
	G. Brewer, RN
	L. Brown, LPN
	~~M. Bryant, RN~~
	G. Capshaw, RN
	L. Carlson, RN, DON
	T. Case, LPN
	~~G. Catherman, LPN~~
	P. Cleveland, MA
	A. Cooley, LPN

Date	Initials	Staff Signature
	~~R. Daugherty, LPN~~	
	J. Drake, LPN	
	V. Ferro, LPN	
	M. Gonzalez, LPN	
	~~M. Grace, RN~~	
	~~L. Green, RN~~	
	S. Harrod, MA	
	L. Hill, PhT	
	A. Huddleston, C N A	
	D. Iensen, LPN	
	~~S. Kitto, RN~~	
	K. Larsen, LPN	
	T. Lee, RN	
	S. Mallet, LPN	
	C. Marria, LPN	
	T. Mccall, LPN	
	L. Moser, C N A	

Date	Initials	Staff Signature
		K. Murray, RN
		~~A. Nisby, LPN~~
		S. Patterson, LPN
		S. Perus, LPN
		H. Pierce, LPN
		~~J. Prudhomme, LPN~~
		D. Rainier, LPN
		~~G. Read, LPN~~
		E. Reed, LPN
		G. Rodriguez, LPN
		J. Savell, LPN
		~~A. Thurber, LPN~~
		~~D. Walthall, RN~~
		C. Wilcox C N A
		C. Wilson, LPN
		W. Wingert, RN, DON
		C. Young, LPN
		~~A. Nisby, LPN~~
		C Curtis LPN

Date/Time	NOTES
6-4-15 AM	Absent
6/27/15 Kop	Absent

ER 2093

Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID **Month:** June 2015

Init.	Drug - Dose - Mode - Interval	HR
SH	VENLAFAXINE HCL 75 MG TABS ~EFFEXOR~ [illegible] TAKE 1 TAB BY MOUTH EVERY MORNING FOR 120 DAYS >> TAKE WITH FOOD; MAY CAUSE DROWSINESS << Prescriber SEYS,JANE,NP Rx#32937108 Order Date 04/30/15 Start Date 4-30 Stop Date 08/28/15	A
	Calcium Carb 1250mg / Vit D 1250mg po Qday x210day Prescriber [illegible] Order Date [illegible] Start Date [illegible] Stop Date [illegible]	KOP
	estrace 1mg iii po Qday x90days Prescriber [illegible] Order Date [illegible] Start Date Stop Date	
	Proscar 5mg i po Qday x 90days Prescriber [illegible] Order Date [illegible] Start Date Stop Date	
	Prescriber Order Date Start Date Stop Date	
	Prescriber Order Date Start Date Stop Date	

[redacted]

Diagnosis: No Known Drug Allergy

Allergies:

94691 (DOB/Inmate #:) 6340- MAIN(00) (Location:) EDMO, MASON (Name:)

2/2

PharmaCorr

#3150 REV 4/10

Medication Administration Record

Documentation Codes	Staff Signature	Date	Initials
D/C - Discont	~~C. Ahearn, RN~~		
R - Refused	~~J. Allen, RN~~		
A - Absent	~~K. Barkley, LPN~~		
O - Other	~~M. Beek, RN~~		
	A. Benton, LPN		
	A. Beshears, RN		
	~~G. Blackburn, LPN~~		
	C. Brenenstahl, dialysis tech		
	G. Brewer, RN		
	L. Brown, LPN		
	~~M. Bryant, RN~~		
	G. Capshaw, RN		
	L. Carlson, RN, DON		
	T. Case, LPN		
	~~G. Catherman, LPN~~		
	P. Cleveland, MA		
	A. Cooley, LPN		

Staff Signature	Date	Initials
~~R. Daugherty, LPN~~		
J. Drake, LPN		
V. Ferro, LPN		
M. Gonzalez, LPN		
~~M. Grace, RN~~		
~~L. Green, RN~~		
S. Harrod, MA		
L. Hill, PhT		
A. Huddleston, C N A		
D. Jensen, LPN		
~~S. Kitto, RN~~		
K. Larsen, LPN		
T. Lee, RN		
S. Mallet, LPN		
C. Marria, LPN		
T. Mccall, LPN		
L. Moser, C N A		

Staff Signature	Date	Initials
K. Murray, RN		
~~A. Nisby, LPN~~		
S. Patterson, LPN		
S. Perus, LPN		
H. Pierce, LPN		
~~J. Prudhomme, LPN~~		
D. Rainier, LPN		
~~C. Read, LPN~~		
E. Reed, LPN		
G. Rodriguez, LPN		
J. Savell, LPN		
~~A. Thurber, LPN~~		
~~D. Walthall, RN~~		
C. Wilcox C N A		
C. Wilson, LPN		
W. Wingert, RN, DON		
C. Young, LPN		
~~A. Nisby, LPN~~		

Date/Time	NOTES
4/27/15	Hop absent pt

ER 2095

Pg.274
Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID **Month:** July 2015

Init.	Drug - Dose - Mode - Interval	HR	Notes (days 1–31)
D	VENLAFAXINE HCL 75 MG TABS ~EFFEXOR~ crush TAKE 1 TAB BY MOUTH EVERY MORNING FOR 120 DAYS >> TAKE WITH FOOD; MAY CAUSE DROWSINESS << Prescriber SEYS,JANE,NP Rx#32937108 Order Date 04/30/15 Start Date 4-30-15 Stop Date 08/28/15	A	Initials for days 1–21 (not all legible); 90 V; Δ to XR & increase
	ASA EC 81mg, ī PO QD x 210 days Prescriber Gelok Order Date 6/26/15 Start Date 6/28/15 Stop Date 1/26/16	K O P	7-2 #30 [illegible]; Edmo; V 30; 7/29/15 #30 7 Edmo
Z	Calcium Carb 1250mg / Vit D 1280mg ī PO QD x 210 Days Prescriber Gelok Order Date 6/26/15 Start Date 6/28/15 Stop Date 1/26/16	K O P	7-2 #30 [illegible]; Edmo
Z	Estradiol 1mg iii PO QD x 90 days I6.8 #90 Approved Prescriber Gelok Order Date 6/26/15 Start Date 7/1/15 Stop Date 10/1/15	K O P	V 90; 7-7 #90 [illegible]; Edmo
Z	Finasteride 5mg, ī PO QD (bag) x 90 days Approved Prescriber Gelok Order Date 6/26/15 Start Date 7/1/15 Stop Date 10/1/15	K O P	V 30; 7-7 #30 [illegible]; Edmo
Z	Spironolactone 100mg ī PO BID x 210 Days Prescriber Gelok Order Date 6/26/15 Start Date 6/28/15 Stop Date 1/26/16	K O P	7-2 #60 [illegible]; Edmo; V 60; 7/29/15 #60 7 Edmo

[redacted]

94691 6340- MAIN(00) EDMO, MASON

Diagnosis:
No Known Drug Allergy

Allergies: DOB/Inmate #: Location: Name: PharmaCorr

#3150 REV 4/10

Medication Administration Record

Documentation Codes	Staff Signature	Date	Initials	Staff Signature	Date	Initials
C. Ahearn, RN		7-2015	A. Cooley, LPN		7-2015	A. Nisby, LPN		7-2015
J. Allen, RN		7-2015	C. Curtis, LPN		7-2015	S. Patterson, LPN		7-2015
D/C - Discontinued Order K. Barney, LPN		7-2015	I. Drake, LPN		7-2015	S. Perus, LPN		7-2015
R - Refused M. Beck, RN		7-2015	V. Ferro, LPN		7-2015	H. Pierce, LPN		7-2015
A. Bennett, LPN		7-2015	M. Gonzalez, LPN		7-2015	J. Prudhomme, LPN		7-2015
A - Absent A. Benton, LPN		7-2015	M. Grace, RN		7-2015	D. Rainier, LPN		7-2015
A. Beshears, RN		7-2015	S. Harrod, MA		7-2015	E. Reed, LPN		7-2015
O - Other G. Blackburn, LPN		7-2015	L. Hill, PhT		7-2015	G. Rodriguez, LPN		7-2015
C. Brenenstahl, dialysis tech		7-2015	A. Huddleston, C N A		7-2015	J. Savell, LPN		7-2015
G. Brewer, RN		7-2015	D. Jensen, LPN		7-2015	A. Thurber, LPN		7-2015
L. Brown, LPN		7-2015	S. Kitto, RN		7-2015	D. Walthall, RN		7-2015
M. Bryant, RN		7-2015	K. Larsen, LPN		7-2015	C. Wilcox C N A		7-2015
G. Capshaw, RN		7-2015	T. Lee, RN		7-2015	C. Wilson, LPN		7-2015
L. Carlson, RN, DON		7-2015	S. Mallet, LPN		7-2015	W. Wingert, RN, DON		7-2015
T. Case, LPN		7-2015	C. Marria, LPN		7-2015	C. Young, LPN		7-2015
G. Catherman, LPN		7-2015	T. Mccall, LPN		7-2015			7-2015
P. Cleveland, MA		7-2015	L. Moser, C N A		7-2015			7-2015
A. Cooper MA		7-2015	K. Murray, RN		7-2015			7-2015
		7-2015			7-2015			7-2015

Date/Time	NOTES
7-28	AM Absent MS

ER 2097

MEDICATION ADMINISTRATION RECORD

Facility: LSCI

Month: 7-2015

Init.	Drug - Dose - Mode - Interval	HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	Effexor XR 150mg PO q AM x120 days Prescriber: Jeremy Stoddart, MD Order Date 7/21 Start Date 7/22 Stop Date 11/21																							30									
	Prescriber Order Date Start Date Stop Date																																
	Prescriber Order Date Start Date Stop Date																																
	Prescriber Order Date Start Date Stop Date																																
	Prescriber Order Date Start Date Stop Date																																
	Prescriber Order Date Start Date Stop Date																																

Diagnosis:

Allergies: NKDA

[redacted] 9469

DOB/Inmate #:

Location:

2/2

Name: Edmo, Mason

#3150 REV 4/10

ER 2098

Medication Administration Record

Documentation Codes	Staff Signature	Date	Initials
	C. Ahearn, RN	7-2015	
	J. Allen, RN	7-2015	
D/C - Discontinued Order	K. Barney, LPN	7-2015	
	M. Beck, RN	7-2015	
R - Refused	A. Bennett, LPN	7-2015	
	A. Benton, LPN	7-2015	
A - Absent	A. Beshears, RN	7-2015	
O - Other	G. Blackburn, LPN	7-2015	
	C. Brenenstahl, dialysis tech	7-2015	
	G. Brewer, RN	7-2015	
	L. Brown, LPN	7-2015	
	M. Bryant, RN	7-2015	
	G. Capshaw, RN	7-2015	
	L. Carlson, RN, DON	7-2015	
	T. Case, LPN	7-2015	
	G. Catherman, LPN	7-2015	
	P. Cleveland, MA	7-2015	
	A. Cooper MA	7-2015	
		7-2015	

Date	Initials	Staff Signature	Date	Initials
A. Cooley, LPN			7-2015	
C. Curtis, LPN			7-2015	
J. Drake, LPN			7-2015	
V. Ferro, LPN			7-2015	
M. Gonzales, LPN			7-2015	
M. Grace, RN			7-2015	
S. Harrod, MA			7-2015	
L. Hill, PHT			7-2015	
A. Huddleston, C N A			7-2015	
D. Jensen, LPN			7-2015	
S. Kitto, RN			7-2015	
K. Larsen, LPN			7-2015	
T. Lee, RN			7-2015	
S. Mallet, LPN			7-2015	
C. Marria, LPN			7-2015	
T. Mccall, LPN			7-2015	
L. Moser, C N A			7-2015	
K. Murray, RN			7-2015	
			7-2015	

Staff Signature	Date	Initials
A. Nisby, LPN		
S. Patterson, LPN		
S. Perus, LPN		
H. Pierce, LPN		
J. Prudhomme, LPN		
D. Rainier, LPN		
E. Reed, LPN		
G. Rodriguez, LPN		
J. Savell, LPN		
A. Thurber, LPN		
D. Walthall, RN		
C. Wilcox C N A		
C. Wilson, LPN		
W. Wingert, RN, DON		
C. Young, LPN		

Date/Time	NOTES
7-10-15 am absent SH	
7-20-15 AM absent SH	

ER 2099

Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M **6340-** IDAHO STATE CORR INST (ISCI) ID **Month:** August 2015

Int.	Drug - Dose - Mode - Interval	HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	SPIRONOLACTONE 100 MG TABS ~ALDACTONE~ TAKE 1 TAB BY MOUTH TWICE DAILY FOR 210 DAYS >> MAY CAUSE DIZZINESS << Prescriber GELOK,CHRISTIAN,NP Rx#33321099 Order Date 06/26/15 Start Date 6/27 Stop Date 01/22/16	K 8 PM	AM										1 2								7 PE	7											
	VENLAFAXINE HCL XR 150 MG CP24 ~EFFEXOR XR~ TAKE 1 CAP BY MOUTH EACH MORNING FOR 120 DAYS >> DO NOT CRUSH; MAY CAUSE DROWSINESS << Prescriber STODDART,JEREMY,MD Rx#33482721 Order Date 07/21/15 Start Date 7/22 Stop Date 11/18/15										1								30													NEW
	Effexor XR 150mg PO qAM AM Prescriber Order Date 8/26 Start Date 8/27 Stop Date 12/26																																
	Prescriber Order Date Start Date Stop Date																																
	Prescriber Order Date Start Date Stop Date																																
	Prescriber Order Date Start Date Stop Date																																

Diagnosis: No Known Drug Allergy

Allergies:

[redacted] 94691 DOB/Inmate #:

6340- MAIN(00) Location:

EDMO, MASON 2/2 Name:

PharmaCorr

#3150 REV 4/10

ER 2100

Medication Administration Record

Documentation Codes	Staff Signature	Date	Initials	Staff Signature	Date	Initials
~~C. Ahearn, RN~~		8-2015	~~A. Cooley, LPN~~		8-2015	L. Moser, C N A	LM	8-2015	
J. Allen, RN		8-2015	A. Cooper, MA	AC	8-2015	~~K. Murray, RN~~		8-2015	
K. Barney, LPN		8-2015	C. Curtis, LPN	CC	8-2015	A. Nisby, LPN	LN	8-2015	
M. Beck, RN		8-2015	J. Drake, LPN		8-2015	S. Patterson, LPN		8-2015	
~~A. Bennett, LPN~~		8-2015	V. Ferro, LPN			S. Perus, LPN		8-2015	
A. Benton, LPN		8-2015	M. Gonzalez, LPN		8-2015	H. Pierce, LPN		8-2015	
A. Beshears, RN		8-2015	~~M. Grace, RN~~		8-2015	~~S. Pedlhomme, LPN~~		8-2015	
~~G. Blackburn, LPN~~		8-2015	S. Harrod, MA	SH	8-2015	D. Rainier, LPN		8-2015	
C. Brenenstahl, dialysis tech		8-2015	L. Hill, PhT		8-2015	E. Reed, LPN		8-2015	
~~Brewer, RN~~		8-2015	A. Huddleston, C N A		8-2015	G. Rodriguez, LPN		8-2015	
own, LPN		8-2015	D. Jensen, LPN		8-2015	J. Savell, LPN		8-2015	
~~Bryant, RN~~		8-2015	~~S. Kitto, RN~~		8-2015	~~A. Thurber, LPN~~		8-2015	
G. Capshaw, RN		8-2015	~~K. Larsen, LPN~~		8-2015	~~D. Walthall, RN~~		8-2015	
L. Carlson, RN, DON		8-2015	T. Lee, RN		8-2015	~~G. Wilcox C N A~~		8-2015	
T. Case, LPN		8-2015	S. Mallet, LPN		8-2015	C. Wilson, LPN		8-2015	
~~C. Catherman, LPN~~		8-2015	C. Marria, LPN		8-2015	W. Wingert, RN, DON		8-2015	
P. Cleveland, MA		8-2015	T. Mccall, LPN		8-2015	C. Young, LPN		8-2015	
A. Mateo, RN		8-2015			8-2015			8-2015	
S. Deeds, RN		8-2015			8-2015			8-2015	

D - Discontinued Order
R - Refused
A - Absent

Date/Time	NOTES
8-15-15	kep absent k-SH

ER 2101

Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID **Month:** August 2015

Init.	Drug - Dose - Mode - Interval
	ASPIRIN EC 81 MG TBEC ~ECOTRIN~ TAKE 1 TAB BY MOUTH EVERY DAY FOR 210 DAYS >> DO NOT CRUSH << Prescriber GELOK,CHRISTIAN,NP Rx#33321090 Order Date 06/26/15 Start Date 6/28 Stop Date 01/22/16
	CALCIUM CARB 1250MG/VIT D 1250 MG TABS ~OSCAL-D 500~ TAKE 1 TAB BY MOUTH DAILY FOR 210 DAYS Prescriber WHINNERY,CATHERINE Rx#32241747 Order Date 01/09/15 Start Date Stop Date 08/07/15
	CALCIUM CARB 1250MG/VIT D 1250 MG TABS ~OSCAL-D 500~ TAKE 1 TAB BY MOUTH EVERY DAY FOR 210 DAYS Prescriber GELOK,CHRISTIAN,NP Rx#33321092 Order Date 06/26/15 Start Date 6/28 Stop Date 01/22/16
	ESTRADIOL 1 MG TABS ~ESTRACE~ TAKE 3 TABS (3MG) BY MOUTH EVERY DAY FOR 90 DAYS **APPROVED** Prescriber GELOK,CHRISTIAN,NP Rx#33347885 Order Date 07/01/15 Start Date 7/1 Stop Date 09/29/15
	FINASTERIDE 5 MG TABS ~PROSCAR~ AKE 1 TAB BY MOUTH EVERY DAY FOR 90 DAYS **APPROVED** >>WOMEN OF CHILD BEARING AGE SHOULD NOT HANDLE THIS DRUG<< Prescriber GELOK,CHRISTIAN,NP Rx#33347887 Order Date 07/01/15 Start Date 7/1 Stop Date 09/29/15
	Prescriber Order Date Start Date Stop Date

[redacted]

Diagnosis: No Known Drug Allergy	DOB/Inmate #: 94691	Location: 6340- MAIN(00)	Name: EDMO, MASON 1/2
Allergies:			PharmaCorr

#3150 REV 4/10

Medication Administration Record

Documentation Codes / Staff Signature	Date	Staff Signature	Date	Staff Signature	Date
~~C. Ahearn, RN~~	8-2015	~~A. Cooley, LPN~~	8-2015	L. Moser, C N A	8-2015
J. Allen, RN	8-2015	A. Cooper, MA	8-2015	~~K. Murray, RN~~	8-2015
K. Barney, LPN (D - Discontinued Order)	8-2015	C. Curtis, LPN	8-2015	A. Nisby, LPN	8-2015
M. Beck, RN	8-2015	J. Drake, LPN	8-2015	S. Patterson, LPN	8-2015
~~A. Bennett, LPN~~ (R - Refused)	8-2015	~~V. Ferro, LPN~~	8-2015	~~S. Perus, LPN~~	8-2015
A. Benton, LPN (A - Absent)	8-2015	M. Gonzalez, LPN	8-2015	H. Pierce, LPN	8-2015
A. Beshears, RN	8-2015	~~M. Grace, RN~~	8-2015	~~J. Prudhomme, LPN~~	8-2015
~~G. Blackburn, LPN~~ (O - Other)	8-2015	S. Harrod, MA	8-2015	D. Rainier, LPN	8-2015
C. Brenenstahl, dialysis tech	8-2015	L. Hill, PhT	8-2015	E. Reed, LPN	8-2015
G. Brewer, RN	8-2015	A. Huddleston, C N A	8-2015	G. Rodriguez, LPN	8-2015
own, LPN	8-2015	D. Jensen, LPN	8-2015	J. Savell, LPN	8-2015
~~M. Bryant, RN~~	8-2015	~~S. Kitto, RN~~	8-2015	~~A. Thurber, LPN~~	8-2015
G. Capshaw, RN	8-2015	~~H. Larsen, LPN~~	8-2015	~~D. Walthall, RN~~	8-2015
L. Carlson, RN, DON	8-2015	T. Lee, RN	8-2015	~~G. Wilcox C N A~~	8-2015
T. Case, LPN	8-2015	S. Mallet, LPN	8-2015	C. Wilson, LPN	8-2015
~~C. Catherman, LPN~~	8-2015	C. Marria, LPN	8-2015	W. Wingert, RN, DON	8-2015
P. Cleveland, MA	8-2015	T. Mccall, LPN	8-2015	C. Young, LPN	8-2015
A. Mateo, RN	8-2015		8-2015		8-2015
S. Deeds, RN	8-2015		8-2015		8-2015

Date/Time	NOTES
~~8-19-15~~	~~Am absent SH~~
8-19-15	Am In unit 16.

ER 2103

Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID **Month:** September 2015

Ini.	Drug - Dose - Mode - Interval	HR
	~~ASPIRIN EC 81 MG TBEC ~ECOTRIN~~ I22 8/23 TAKE 1 TAB BY MOUTH EVERY DAY FOR 210 DAYS >> DO NOT CRUSH << Prescriber GELOK,CHRISTIAN,NP Rx#33321090 Order Date 06/26/15 Start Date 6/28/15 Stop Date 01/22/16	K O P
	~~CALCIUM CARB 1250MG/VIT D 1250 MG TABS ~OSCAL-D 500~~ I24 8/23 TAKE 1 TAB BY MOUTH EVERY DAY FOR 210 DAYS Prescriber GELOK,CHRISTIAN,NP Rx#33321092 Order Date 06/26/15 Start Date 6/28/15 Stop Date 01/22/16	K O P
	ESTRADIOL 1 MG TABS ~ESTRACE~ I40 8/23 TAKE 3 TABS (3MG) BY MOUTH EVERY DAY FOR 90 DAYS **APPROVED** Prescriber GELOK,CHRISTIAN,NP Rx#33347885 Order Date 07/01/15 Start Date 7/1/15 Stop Date 09/29/15	K O P
	FINASTERIDE 5 MG TABS ~PROSCAR~ I24 8/23 TAKE 1 TAB BY MOUTH EVERY DAY FOR 90 DAYS **APPROVED** >>WOMEN OF CHILD BEARING AGE SHOULD NOT HANDLE THIS DRUG<< Prescriber GELOK,CHRISTIAN,NP Rx#33347887 Order Date 07/01/15 Start Date 7/1/15 Stop Date 09/29/15	K O P
	SPIRONOLACTONE 100 MG TABS ~ALDACTONE~ I13 8/23 KE 1 TAB BY MOUTH TWICE DAILY FOR 210 DAYS >> MAY CAUSE DIZZINESS << Prescriber GELOK,CHRISTIAN,NP Rx#33321099 Order Date 06/26/15 Start Date 6/29/15 Stop Date 01/22/16	K O P
	Effexor XR 150mg PO qAM Prescriber Scott Eliason, MD Order Date 8/26 Start Date 8/27 Stop Date 12/26	A

Diagnosis: No Known Drug Allergy

Allergies:

[redacted] 94691 6340- MAIN(00) EDMO, MASON

DOB/Inmate #: Location: Name:

PharmaCorr

#3150 REV 4/10

ER 2104

ER 2105

Medication Administration Record

Documentation Codes	Staff Signature		Date	Initials	Staff Signature		Date	Initials
	~~C. Affearn, RN~~		A. Cooper, MA	AC AC Cooper	9-2015	T. Mccall, LPN	TM TM Mccall	9-2015
	~~B. Allen, RN~~		~~C. Curtis, LPN~~		9-2015	~~L. Moser, C N A~~		9-2015
D/C - Discontinued	~~K. Barney, LPN~~		S. Deeds, RN	SD	9-2015	A. Nisby, LPN	NB	9-2015
	M. Beck, RN		J. Drake, LPN	JD	9-2015	~~S. Patterson, LPN~~		9-2015
R - Refused	~~K. Bennett, RN~~		~~V. Ferro, LPN~~		9-2015	S. Perus, LPN		9-2015
A - Absent	A. Benton, LPN		~~M. Gonzales, LPN~~		9-2015	H. Pierce, LPN		9-2015
	A. Beshears, RN		M. Grace, RN	MG	9-2015	~~J. Prudhomme, LPN~~		9-2015
O - Other	~~G. Blackburn, LPN~~		S. Harrod, MA SMA	SH	9-2015	D. Rainier, LPN		9-2015
	C. Brenenstahl, dialysis tech		S. Hawk, LPN	SH	9-2015	E. Reed, LPN		9-2015
	G. Brewer, RN		L. Hill, PhT	L	9-2015	G. Rodriguez, LPN		9-2015
	L. Brown, LPN		A. Huddleston, C N A	AH	9-2015	J. Savell, LPN		9-2015
	~~M. Bryant, RN~~		D. Jensen, LPN	DJ	9-2015	~~A. Thurber, LPN~~		9-2015
	G. Capshaw, RN		~~B. Witter, RN~~		9-2015	~~B. Walthall, RN~~		9-2015
	L. Carlson, RN, DON		K. Larsen, LPN	KL	9-2015	~~C. Wilcox C N A~~		9-2015
	T. Case, LPN		~~T. Lee, RN~~		9-2015	~~C. Wilson, LPN~~		9-2015
	~~G. Catherman, LPN~~		~~A. Mukes, RN~~		9-2015	W. Wingert, RN, DON		9-2015
	P. Cleveland, MA		S. Mallet, LPN	SM	9-2015	C. Young, LPN		9-2015
	~~A. Cooley, LPN~~		C. Marria, LPN		9-2015			9-2015
	K. Barney, LPN		Cody Barnes CMS		9-2015			9-2015

Date/Time	NOTES
9-30-15 Am	Absent for Hall

Pg:295
Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID **Month:** September 2015

Init	Drug - Dose - Mode - Interval	HR	1–31
ar	VENLAFAXINE HCL XR 150 MG CP24 ~EFFEXOR XR~ 8/18 V30 TAKE 1 CAP BY MOUTH EACH MORNING FOR 120 DAYS >> DO NOT CRUSH; MAY CAUSE DROWSINESS << Prescriber STODDART,JEREMY,MD Rx#33482721 Order Date 07/21/15 Start Date 7/22/15 Stop Date 11/18/15	AM	NEW ORDER
R	Estradiol 3 mg PO QAM x90 days Single Dose Prescriber Poulson Order Date 9/24 Start Date 9/27 Stop Date 12/27	A	9/28/15 2
	Prescriber Order Date Start Date Stop Date		
	Prescriber Order Date Start Date Stop Date		
	Prescriber Order Date Start Date Stop Date		
	Prescriber Order Date Start Date Stop Date		

Diagnosis:
Allergies: No Known Drug Allergy

DOB/Inmate #: [redacted] 94691
Location: 6340- MAIN(00)
Name: EDMO, MASON

PharmaCorr

#3150 REV 4/10

Medication Administration Record

Documentation Codes	Staff Signature	Initials / Signature		Date	Staff Signature	Initials / Signature		Date	Staff Signature	Initials / Signature		Date
	~~G. Ahearn, RN~~			9-2015	A. Cooper, MA	AC	A Cooper	9-2015	T. Mccall, LPN	[illegible]	[illegible]	9-2015
	~~S. Allen, RN~~			9-2015	~~L. Curtis, LPN~~			9-2015	~~L. Moser, C N A~~			9-2015
D/C - Discont	~~K. Bailey, LPN~~	MB	[illegible]	9-2015	S. Deeds, RN	SD	[illegible]	9-2015	A. Nisby, LPN	ANB	[illegible]	9-2015
	M. Beck, RN			9-2015	J. Drake, LPN	JD	[illegible]	9-2015	~~S. Patterson, LPN~~			9-2015
R - Refused	~~A. Bennett, LPN~~	AB	[illegible]	9-2015	~~V. Ferro, LPN~~			9-2015	~~S. Perus, LPN~~	[illegible]	[illegible]	9-2015
A - Absent	A. Benton, LPN	AB	[illegible]	9-2015	~~M. Gonzales, LPN~~			9-2015	H. Pierce, LPN	[illegible]	H Pierce	9-2015
	A. Beshears, RN	AB	[illegible]	9-2015	M. Grace, RN	MG	[illegible]	9-2015	~~J. Prudhomme, LPN~~			9-2015
O - Other	~~G. Blackburn, LPN~~			9-2015	S. Harrod, MA SMH	SH	[illegible]	9-2015	D. Rainier, LPN	[illegible]	[illegible]	9-2015
	C. Brenenstahl, dialysis tech	CB	[illegible]	9-2015	S. Hawk, LPN	SH	[illegible]	9-2015	E. Reed, LPN	[illegible]	[illegible]	9-2015
	G. Brewer, RN	GB	[illegible]	9-2015	L. Hill, PhT	L	[illegible]	9-2015	G. Rodriguez, LPN	[illegible]	[illegible]	9-2015
	L. Brown, LPN	LB	[illegible]	9-2015	A. Huddleston, C N A	AH	A. Huddleston	9-2015	J. Savell, LPN	[illegible]	[illegible]	9-2015
	~~M. Bryant, RN~~			9-2015	D. Jensen, LPN	DJ	[illegible]	9-2015	~~A. Thurber, LPN~~			9-2015
	G. Capshaw, RN	[illegible]	[illegible]	9-2015	~~S. Kitto, RN~~			9-2015	~~D. Walthall, RN~~			9-2015
	L. Carlson, RN, DON	[illegible]	L Carlson	9-2015	K. Larsen, LPN	KL	K Larsen	9-2015	~~C. Wilcox C N A~~			9-2015
	T. Case, LPN	TC	T Case [illegible]	9-2015	~~T. Lee, RN~~			9-2015	~~C. Wilson, LPN~~			9-2015
	~~C. Catherman, LPN~~			9-2015	~~A. Makes, RN~~			9-2015	W. Wingert, RN, DON	W	[illegible]	9-2015
	P. Cleveland, MA	[illegible]	Penny Cleveland	9-2015	S. Mallet, LPN	S	S Mallet	9-2015	C. Young, LPN	[illegible]	[illegible]	9-2015
	~~A. Cooley, LPN~~			9-2015	C. Marria, LPN	[illegible]	[illegible]	9-2015				9-2015
	K. Barnes LPN	KB	[illegible]	9-2015	Cody Hoopes CMS	[illegible]	[illegible]	9-2015				9-2015

NOTES

Date/Time		Notes
8/30/15	[illegible]	referral sent to provider for expiring meds [illegible]
[illegible] absent KOP c/o [illegible]		
[illegible]-30-15	AM	Absent [illegible] IV Holding 16
[illegible]-30-15	AM	No Spirolactone 28

Pg:288
Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID **Month:** October 2015

Init.	Drug - Dose - Mode - Interval	HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	ASPIRIN EC 81 MG TBEC ~ECOTRIN ~ #30 9-21 TAKE 1 TAB BY MOUTH EVERY DAY FOR 210 DAYS >> DO NOT CRUSH << Prescriber GELOK,CHRISTIAN,NP Rx#33321090 Order Date 06/26/15 Start Date 6-26-15 Stop Date 01/22/16	K O P																														
	CALCIUM CARB 1250MG/VIT D 1250 MG TABS ~OSCAL-D 500~ TAKE 1 TAB BY MOUTH EVERY DAY FOR 210 DAYS ∅ Sept Prescriber GELOK,CHRISTIAN,NP Rx#33321092 Order Date 06/26/15 Start Date 6-26-15 Stop Date 01/22/16	K O P																														
	SPIRONOLACTONE 100 MG TABS ~ALDACTONE~ #60 9-21 TAKE 1 TAB BY MOUTH TWICE DAILY FOR 210 DAYS >> MAY CAUSE DIZZINESS << Prescriber GELOK,CHRISTIAN,NP Rx#33321099 Order Date 06/26/15 Start Date 6-28-15 Stop Date 01/22/16	K O P																														
	VENLAFAXINE HCL XR 150 MG CP24 ~EFFEXOR XR~ #30 9-9 TAKE 1 CAP BY MOUTH EACH MORNING FOR 120 DAYS >> DO NOT CRUSH; MAY CAUSE DROWSINESS << Prescriber ELIASON,SCOTT PSY Rx#33726058 Order Date 08/26/15 Start Date 8-27-15 Stop Date 12/24/15	AM																														
	Estradiol 1mg Single Dose 3tabs PO Q AM x90days #90 9-26 Prescriber Poulson Order Date 9/24 Start Date 9/27 Stop Date 12/27	AM																														
	Estradiol 1mg 4tabs po qam Single DOSE x90days Prescriber Poulson Order Date 10-8-15 Start Date 10-11-15 Stop Date 1-8-16	A																														

Diagnosis: No Known Drug Allergy

Allergies:

[redacted] 94691 DOB/Inmate #:

6340- MAIN(00) Location:

EDMO, MASON Name:

PharmaCorr

#3150 REV 4/10

ER 2108

Medication Administration Record

Documentation Codes	Staff Signature	Date	Initials
D/C - Discontinued Order	~~S. Abrams, RN~~	10-2015	
R - Refused	~~J. Allen, RN~~	10-2015	
A- Absent	K. Barney, LPN	10-2015	
O - Other	M. Beck, RN	10-2015	
	~~A. Bennett, LPN~~	10-2015	
	A. Benton, LPN	10-2015	
	A. Beshears, RN	10-2015	
	~~S. Blackburn, LPN~~	10-2015	
	C. Brenenstahl, dialysis tech	10-2015	
	G. Brewer, RN	10-2015	
	L. Brown, LPN	10-2015	
	M. Bryant, RN	10-2015	
	G. Capshaw, RN	10-2015	
	L. Carlson, RN, DON	10-2015	
	T. Case, LPN	10-2015	
	~~S. Catherman, LPN~~	10-2015	
	P. Cleveland, MA	10-2015	
	A. Cooper, MA	10-2015	
	A. Pope, CNA (Bryant)	10-2015	

Staff Signature	Date	Initials
C. Curtis, LPN	10-2015	
S. Deeds, RN	10-2015	
J. Drake, LPN	10-2015	
V. Ferro, LPN	10-2015	
~~M. Gonzales, LPN~~	10-2015	
M. Grace, RN	10-2015	
S. Harrod, MA	10-2015	
S. Hawk, LPN	10-2015	
L. Hill, PhT	10-2015	
N. Hoffman, LPN	10-2015	
~~C. Hooper, CMA~~	10-2015	
A. Huddleston, C N A	10-2015	
D. Jensen, LPN	10-2015	
~~K. Jensen, LPN~~	10-2015	
T. Lee, RN	10-2015	
~~M. Mukes, RN~~	10-2015	
~~S. Mallet, LPN~~	10-2015	
	10-2015	
	10-2015	

Staff Signature	Date	Initials
C. Marria, LPN	10-2015	
T. Mccall, LPN	10-2015	
L. Moser, C N A	10-2015	
A. Nisby, LPN	10-2015	
S. Patterson, LPN	10-2015	
S. Perus, LPN	10-2015	
H. Pierce, LPN	10-2015	
D. Rainier, ~~LPN~~	10-2015	
E. Reed, LPN	10-2015	
G. Rodriguez, LPN	10-2015	
J. Savell, LPN	10-2015	
~~A. Thurber, LPN~~	10-2015	
~~D. Walkhall, RN~~	10-2015	
C. Wilcox C N A	10-2015	
C. Wilson, LPN	10-2015	
W. Wingert, RN, DON	10-2015	
C. Young, LPN	10-2015	
	10-2015	
	10-2015	

Date/Time	NOTES

ER 2109

MEDICATION ADMINISTRATION RECORD

Facility: ISCI **Month:** Nov 2015

Init.	Drug - Dose - Mode - Interval	HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	Effexor XR 150mg Po q AM x120 days Jane Seys, PNP Prescriber Order Date 11/19 Start Date 11/20 Stop Date 3/19	A																															
	Prescriber Order Date Start Date Stop Date																																
	Prescriber Order Date Start Date Stop Date																																
	Prescriber Order Date Start Date Stop Date																																
	Prescriber Order Date Start Date Stop Date																																
	Prescriber Order Date Start Date Stop Date																																

Diagnosis:

Allergies: NKDA

[redacted] 94691

DOB/Inmate #: Location:

2/2

Name: Edmo, Mason

Medication Administration Record

Documentation Codes	Staff Signature	Date	Initials
	K. Barney, LPN		
	M. Beck, RN		
D/C - Discontinued	A. Bennett, LPN		
	A. Benton, LPN		
R - Refused	A. Beshears, RN		
	G. Blackburn, LPN		
A - Absent	C. Brenenstahl, dialysis tech		
O - Other	G. Brewer, RN		
	L. Brown, LPN		
	M. Bryant, RN		
	G. Capshaw, RN		
	L. Carlson, RN, DON		
	T. Case, LPN		
	P. Cleveland, MA		
	A. Cooper, MA		
	C. Curtis, LPN		

Staff Signature	Date	Initials
S. Deeds, RN		
J. Drake, LPN		
V. Ferro, LPN		
~~M. Gonzalez, LPN~~		
M. Grace, RN		
S. Harrod, MA		
S. Hawk, LPN		
L. Hill, PhT		
N. Hoffman, LPN		
~~S. Hooper, CMA~~		
A. Huddleston, C N A		
D. Jensen, LPN		
K. Larsen, LPN		
T. Lee, RN		
S. Mallet, LPN		
C. Marria, LPN		
Rachel Dibben		

Staff Signature	Date	Initials
T. Mccall, LPN		
L. Moser, C N A		
A. Nisby, LPN		
S. Patterson, LPN		
~~S. Perus, LPN~~		
H. Pierce, LPN		
A. Pope, C N A		
D. Rainier, LPN		
E. Reed, LPN		
G. Rodriguez, LPN		
J. Savell, LPN		
C. Wilcox C N A		
C. Wilson, LPN		
W. Wingert, RN, DON		
C. Young, LPN		
Natasha Homme, LPN		

Date/Time	NOTES

ER 2111

Medication Administration Record

Documentation Codes	Staff Signature	Initials	Date	Staff Signature	Initials	Date	Staff Signature	Initials	Date
	K. Barney, LPN	[signature]	12-2015	R. Dibben, C N A	[signature]	12-2015	C. Marria, LPN	[signature]	12-2015
	~~M. Beck, RN~~	[signature]	12-2015	~~J. Drake, LPN~~	[signature]	12-2015	~~T. Mccall, LPN~~	[signature]	12-2015
D/C - Discontinued Order	A. Bennett, LPN	[signature]	12-2015	V. Ferro, LPN	[signature]	12-2015	[redacted]		12-2015
	A. Benton, LPN	[signature]	12-2015	M. Gonzales, LPN	[signature]	12-2015	A. Nisby, LPN	[signature]	12-2015
R - Refused	A. Beshears, RN	[signature]	12-2015	M. Grace, RN	[signature]	12-2015	S. Patterson, LPN	[signature]	12-2015
	G. Blackburn, LPN	GB [signature]	12-2015	S. Harrod, MA	[signature]	12-2015	S. Perus, LPN	[signature]	12-2015
A - Absent	~~C. Brenenstahl, dialysis tech~~	[signature]	12-2015	~~S. Hawk, LPN~~	[signature]	12-2015	~~H. Pierce, LPN~~	[signature]	12-2015
O - Other	G. Brewer, RN	[signature]	12-2015	L. Hill, PhT	[signature]	12-2015	A. Pope, C N A	[signature]	12-2015
	L. Brown, LPN	[signature]	12-2015	N. Hoffman, LPN	[signature]	12-2015	D. Rainier, LPN	[signature]	12-2015
	[redacted]		12-2015	~~N. Homme, LPN~~	[signature]	12-2015	~~E. Reed, LPN~~	[signature]	12-2015
	G. Capshaw, RN	[signature]	12-2015	C. Hoopes, CMS	[signature]	12-2015	G. Rodriguez, LPN	[signature]	12-2015
	L. Carlson, RN, DON	[signature]	12-2015	A. Huddleston, C N A	[signature]	12-2015	J. Savell, LPN	[signature]	12-2015
	T. Case, LPN	TC [signature]	12-2015	D. Jensen, LPN	DJ [signature]	12-2015	[redacted]	[signature]	12-2015
	P. Cleveland, MA	PC [signature]	12-2015	K. Larsen, LPN	KL [signature]	12-2015	C. Wilson, LPN	[signature]	12-2015
	A. Cooper, MA	AC [signature]	12-2015	T. Lee, RN	[signature]	12-2015	W. Wingert, RN, DON	[signature]	12-2015
	C. Curtis, LPN	[signature]	12-2015	S. Mallet, LPN	[signature]	12-2015	C. Young, LPN	[signature]	12-2015
	S. Deeds, RN	[signature]	12-2015	D. Wilson CNA	[signature]	12-2015	L. Tice, CNA	LT [signature]	12-2015
			12-2015			12-2015	Patricia Cash, RN		12-2015
			12-2015			12-2015		PKCash RN	12-2015

Date/Time	NOTES
1/1/16 P	Oscal D unavailable - ordered
1/2	Oscal D unavailable TC
3/1 P	Oscal unavailable
3/?	Absent TJ
1/31/16	Refused Remeron SH

Pg.284
Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID **Month:** November 2015

Init	Drug - Dose - Mode - Interval	HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	ASPIRIN EC 81 MG TBEC ~ECOTRIN ~ #30 10/16 TAKE 1 TAB BY MOUTH EVERY DAY FOR 210 DAYS >> DO NOT CRUSH << Prescriber GELOK,CHRISTIAN,NP Rx#33321090 Order Date 06/26/15 Start Date 6/26 Stop Date 01/22/16	A P O P					EDMO #30 11/25 COT											S	S	S	S	OO	S	S	S	S		EDMO 11/24/15 #30 R				
	CALCIUM CARB 1250MG/VIT D 1250 MG TABS ~OSCAL-D ~~500~~ 10/16 # TAKE 1 TAB BY MOUTH EVERY DAY FOR 210 DAYS Prescriber GELOK,CHRISTIAN,NP Rx#33321092 Order Date 06/26/15 Start Date 6/26 Stop Date 01/22/16	A P O P					EDMO #30 11/25 COT											S	S	S	S	OO	S	S	S	S		EDMO 11/24/15 #30 R				
	ESTRADIOL 2 MG TABS ~ESTRACE~ TAKE 2 TABS (4MG) BY MOUTH EVERY MORNING FOR 90 DAYS **APPROVED** Prescriber POULSON,WILLIAM NP Rx#34043389 Order Date 10/08/15 Start Date 10/11 Stop Date 01/06/16	A	RC	RC	Z	Z	R	RC	RC	RC	RC	Z	Z	Z	Z	Z	SHK	S	S	S	S	OO	S	S	S	S	RC	RC	RC	RC			
												90 V																					
	SPIRONOLACTONE 100 MG TABS ~ALDACTONE~ #6 10/16 TAKE 1 TAB BY MOUTH TWICE DAILY FOR 210 DAYS >> MAY CAUSE DIZZINESS << Prescriber GELOK,CHRISTIAN,NP Rx#33321099 Order Date 06/26/15 Start Date 8/27 Stop Date 01/22/16	A P O P										V 60						S	S	S	S	OO	S	S	S	S		EDMO 11/24/15 #30 R				
	VENLAFAXINE HCL XR 150 MG CP24 ~EFFEXOR XR~ KE 1 CAP BY MOUTH EACH MORNING FOR 120 DAYS >> DO NOT USH; MAY CAUSE DROWSINESS << Prescriber ELIASON,SCOTT PSY Rx#33726058 Order Date 08/26/15 Start Date 8/27 Stop Date 12/24/15	A	RC	RC	Z	Z	R	RC	RC	RC	RC	Z	Z	Z	Z	Z	SHK	S	S	S													
					V 30																	NEW ORDER											
	Proscar 5mg + PO QD Approved x 90Days Prescriber Barry Order Date 11-5-15 Start Date 11-6-15 Stop Date 25-16	A	→						R	RC	RC	Z	Z	Z	Z	Z	SHK	S	S	S	S	OO	S	S	S	S	RC	RC	RC				
								V 30																									

[redacted] 94691 C74

Diagnosis: No Known Drug Allergy

Allergies:

6340- MAIN(00) Location:

EDMO, MASON Name:

PharmaCorr

#3150 REV 4/10

ER 2113

Medication Administration Record

Documentation Codes	Staff Signature	Date	Initials	Staff Signature	Date	Initials
	K. Barney, LPN		S. Deeds, RN		T. Mccall, LPN	
	M. Beck, RN		J. Drake, LPN		L. Moser, C N A	
D/C - Discontinued Order	A. Bennett, LPN		V. Ferro, LPN		A. Nisby, LPN	
	A. Benton, LPN		~~M. Gonzalez, LPN~~		S. Patterson, LPN	
R - Refused	A. Beshears, RN		M. Grace, RN		S. Perus, LPN	
A - Absent	G. Blackburn, LPN		S. Harrod, MA		H. Pierce, LPN	
	C. Brenenstahl, dialysis tech		S. Hawk, LPN		A. Pope, C N A	
O - Other	G. Brewer, RN		L. Hill, PhT		D. Rainier, LPN	
	L. Brown, LPN		N. Hoffman, LPN		E. Reed, LPN	
	M. Bryant, RN		~~C. Hoopes, CMS~~		G. Rodriguez, LPN	
	G. Capshaw, RN		A. Huddleston, C N A		J. Savell, LPN	
	L. Carlson, RN, DON		D. Jensen, LPN		C. Wilcox C N A	
	T. Case, LPN		K. Larsen, LPN		C. Wilson, LPN	
	P. Cleveland, MA		T. Lee, RN		W. Wingert, RN, DON	
	A. Cooper, MA		S. Mallet, LPN		C. Young, LPN	
	C. Curtis, LPN		C. Marria, LPN			
					Patricia Cash, RN	
			Rachel Dibben		Natasha Homme, LPN	

Date/Time	NOTES

ER 2114

Medication Administration Record

Documentation Codes	Staff Signature	Date	Initials	Staff Signature	Date	Initials
K. Barney, LPN		11-2015	S. Deeds, RN		11-2015	T. Mccall, LPN		11-2015
M. Beck, RN		11-2015	J. Drake, LPN		11-2015	L. Moser, C N A		11-2015
D/C - Discontinued Order A. Bennett, LPN		11-2015	V. Ferro, LPN		11-2015	A. Nisby, LPN		11-2015
A. Benton, LPN		11-2015	~~M. Gonzales, LPN~~		11-2015	S. Patterson, LPN		11-2015
R - Refused A. Beshears, RN		11-2015	M. Grace, RN		11-2015	S. Perus, LPN		11-2015
A - Absent G. Blackburn, LPN		11-2015	S. Harrod, MA		11-2015	H. Pierce, LPN		11-2015
C. Brenenstahl, dialysis tech		11-2015	S. Hawk, LPN		11-2015	A. Pope, C N A		11-2015
O - Other G. Brewer, RN		11-2015	L. Hill, PhT		11-2015	D. Rainier, LPN		11-2015
L. Brown, LPN		11-2015	N. Hoffman, LPN		11-2015	E. Reed, LPN		11-2015
M. Bryant, RN		11-2015	~~C. Hooper, CMT~~		11-2015	G. Rodriguez, LPN		11-2015
G. Capshaw, RN		11-2015	A. Huddleston, C N A		11-2015	J. Savell, LPN		11-2015
L. Carlson, RN, DON		11-2015	D. Jensen, LPN		11-2015	C. Wilcox C N A		11-2015
T. Case, LPN		11-2015	K. Larsen, LPN		2015	C. Wilson, LPN		11-2015
P. Cleveland, MA		11-2015	T. Lee, RN		11-2015	W. Wingert, RN, DON		11-2015
A. Cooper, MA		11-2015	S. Mallet, LPN		11-2015	C. Young, LPN		11-2015
C. Curtis, LPN		11-2015	C. Marria, LPN		11-2015			11-2015
		11-2015			11-2015			11-2015
		11-2015			11-2015			11-2015
		11-2015			11-2015	Natasha Homme, LPN		11-2015

Date/Time	NOTES

ER 2115

Pg:294
Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID **Month:** December 2015

Init	Drug - Dose - Mode - Interval	HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	VENLAFAXINE HCL XR 150 MG CP24 ~EFFEXOR XR~ TAKE 1 CAP BY MOUTH EACH MORNING FOR 120 DAYS >> DO NOT CRUSH; MAY CAUSE DROWSINESS << Prescriber SEYS,JANE,NP Rx#34266417 Order Date 11/20/15 Start Date 11-20-15 Stop Date 03/19/16	A																														
	Aldactone 125 mg po BID x 120 days Prescriber Poulson Order Date 12/23 Start Date 12/24 Stop Date 4/24	K O P																															
	Estradial 4 mg po QD x 90 days Start 1-7 Prescriber Poulson *approved Order Date 12/23 Start Date ~~12~~ 1-7-16 Stop Date 4-6-16	H																														
	ASA 81 mg po QD ~~365~~ days Prescriber Poulson Order Date 12/23 Start Date 12/24 Stop Date 12/24/16	K O P																														
	Oscal D 500mg po BID x 365 days Prescriber Poulson Order Date 12/23 Start Date 12/24 Stop Date 12/23/16	K O P																														
	Proscar 5mg po QD x 90 days (Dag) Prescriber Poulson 12/29 3/28/16 Order Date 12/23 Start Date ~~12/24~~ Stop Date ~~3/24~~	A																														

Diagnosis: No Known Drug Allergy

Allergies:

[redacted] 94691 DOB/Inmate #:

6340- MAIN(00) Location: C74

EDMO, MASON Name:

PharmaCorr

#3150 REV 4/10

ER 2116

Medication Administration Record

Documentation Codes	Staff Signature	Initials	Date	Staff Signature	Initials	Date
	K. Barney, LPN	KB	12-2015	R. Dibben, C N A		12-2015
	M. Beck, RN		12-2015	J. Drake, LPN		12-2015
D/C - Discontinued Order	A. Bennett, LPN		12-2015	V. Ferro, LPN		12-2015
	A. Benton, LPN		12-2015	M. Gonzales, LPN		12-2015
R - Refused	A. Beshears, RN		12-2015	M. Grace, RN		12-2015
A - Absent	G. Blackburn, LPN	GB	12-2015	S. Harrod, MA		12-2015
	C. Brenenstahl, dialysis tech		12-2015	S. Hawk, LPN		12-2015
O - Other	G. Brewer, RN		12-2015	L. Hill, PhT		12-2015
	L. Brown, LPN		12-2015	N. Hoffman, LPN		12-2015
	~~M. Bryant, RN~~		12-2015	N. Homme, LPN		12-2015
	G. Capshaw, RN		12-2015	C. Hoopes, CMS		12-2015
	L. Carlson, RN, DON		12-2015	A. Huddleston, C N A		12-2015
	T. Case, LPN		12-2015	D. Jensen, LPN		12-2015
	P. Cleveland, MA		12-2015	K. Larsen, LPN		12-2015
	A. Cooper, MA		12-2015	T. Lee, RN		12-2015
	C. Curtis, LPN		12-2015	S. Mallet, LPN		12-2015
	S. Deeds, RN		12-2015	D. WILSON CM		12-2015
			12-2015			12-2015
			12-2015			12-2015

Staff Signature	Initials	Date
C. Marria, LPN		12-2015
T. Mccall, LPN		12-2015
~~L. Nisbet, C N A~~		12-2015
A. Nisby, LPN		12-2015
~~S. Patterson, LPN~~		12-2015
S. Perus, LPN		12-2015
H. Pierce, LPN		12-2015
A. Pope, C N A		12-2015
D. Rainier, LPN		12-2015
~~E. Reed, LPN~~		12-2015
G. Rodriguez, LPN		12-2015
J. Savell, LPN		12-2015
~~S. Wilson, LPN~~		12-2015
C. Wilson, LPN		12-2015
W. Wingert, RN, DON		12-2015
C. Young, LPN		12-2015
L. TICE, CNA		12-2015
		12-2015
		12-2015

Date/Time	NOTES

ER 2117

Pg:293
Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID **Month:** December 2015

Int.	Drug - Dose - Mode - Interval	HR
	ASPIRIN EC 81 MG TBEC ~ECOTRIN ~ 11/26 #30 TAKE 1 TAB BY MOUTH EVERY DAY FOR 210 DAYS >> DO NOT CRUSH << Prescriber GELOK,CHRISTIAN,NP Rx#33321090 Order Date 06/26/15 Start Date 06-26-15 Stop Date 01/22/16	K O P
	CALCIUM CARB 1250MG/VIT D 1250 MG TABS ~OSCAL-D 500~ 11/26 #30 TAKE 1 TAB BY MOUTH EVERY DAY FOR 210 DAYS Prescriber GELOK,CHRISTIAN,NP Rx#33321092 Order Date 06/26/15 Start Date 06-26-15 Stop Date 01/22/16	K O P
	ESTRADIOL 2 MG TABS ~ESTRACE~ TAKE 2 TABS (4MG) BY MOUTH EVERY MORNING FOR 90 DAYS **APPROVED** Prescriber POULSON,WILLIAM NP Rx#34043389 Order Date 10/08/15 Start Date 10-08-15 Stop Date 01/06/16	A
	FINASTERIDE 5 MG TABS ~PROSCAR~ BAG TAKE 1 TAB BY MOUTH EVERY DAY FOR 90 DAYS **APPROVED** >>WOMEN OF CHILD BEARING AGE SHOULD NOT HANDLE THIS DRUG<< Prescriber BARRY,DANIEL C Rx#34183187 Order Date 11/05/15 Start Date 11-05-15 Stop Date 02/03/16	A
	SPIRONOLACTONE 100 MG TABS ~ALDACTONE~ 11/26 #90 TAKE 1 TAB BY MOUTH TWICE DAILY FOR 210 DAYS >> MAY CAUSE DIZZINESS << Prescriber GELOK,CHRISTIAN,NP Rx#33321099 Order Date 06/26/15 Start Date 06-26-15 Stop Date 01/22/16	K O P
	Prescriber Order Date Start Date Stop Date	

Diagnosis: No Known Drug Allergy

Allergies:

94691 DOB/Inmate #:

6340- MAIN(00) Location: C74

EDMO, MASON Name:

PharmaCorr

#3150 REV 4/10

ER 2118

Medication Administration Record

Documentation Codes	Staff Signature	Initials	Date
	K. Barney, LPN	KB	12-2015
	M. Beck, RN	MB	12-2015
D/C - Discontinued Order	A. Bennett, LPN	AB	12-2015
	A. Benton, LPN	AB	12-2015
R - Refused	A. Beshears, RN	AB	12-2015
	G. Blackburn, LPN	GB	12-2015
A - Absent	C. Brenenstahl, dialysis tech	CB	12-2015
O - Other	G. Brewer, RN	GB	12-2015
	L. Brown, LPN	LB	12-2015
	[redacted]		12-2015
	G. Capshaw, RN	GC	12-2015
	L. Carlson, RN, DON	LC	12-2015
	T. Case, LPN	TC	12-2015
	P. Cleveland, MA	PC	12-2015
	A. Cooper, MA	AC	12-2015
	C. Curtis, LPN	CC	12-2015
	S. Deeds, RN	SD	12-2015
			12-2015
			12-2015

Documentation Codes	Staff Signature	Initials	Date
	R. Dibben, C N A	RD	12-2015
	J. Drake, LPN	JD	12-2015
	V. Ferro, LPN	VF	12-2015
	M. Gonzales, LPN	MG	12-2015
	M. Grace, RN	MG	12-2015
	S. Harrod, MA	SH	12-2015
	S. Hawk, LPN	SH	12-2015
	L. Hill, PhT	LH	12-2015
	N. Hoffman, LPN	NH	12-2015
	N. Homme, LPN	NH	12-2015
	C. Hoopes, CMS	CH	12-2015
	A. Huddleston, C N A	AH	12-2015
	D. Jensen, LPN	DJ	12-2015
	K. Larsen, LPN	KL	12-2015
	T. Lee, RN	TL	2015
	S. Mallet, LPN	SM	2015
D. WILSON CM		DW	12-2015
			12-2015
			12-2015

Documentation Codes	Staff Signature	Initials	Date
	C. Marria, LPN	CM	12-2015
	T. Mccall, LPN	TM	12-2015
	[redacted]		12-2015
	A. Nisby, LPN	AN	12-2015
	S. Patterson, LPN	SP	12-2015
	S. Perus, LPN	SP	12-2015
	H. Pierce, LPN	HP	12-2015
	A. Pope, C N A	AP	12-2015
	D. Rainier, LPN	DR	12-2015
	E. Reed, LPN	ER	12-2015
	G. Rodriguez, LPN	GR	12-2015
	J. Savell, LPN	JS	12-2015
	[redacted]		12-2015
	C. Wilson, LPN	CW	12-2015
	W. Wingert, RN, DON	WW	12-2015
	C. Young, LPN	CY	12-2015
L. TICE, CNA		LT	12-2015
			12-2015
			12-2015

Date/Time	NOTES

Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID **Month:** January 2016

Init.	Drug - Dose - Mode - Interval	HR	Days 1–31
	ASPIRIN EC 81 MG TBEC ~ECOTRIN ~ TAKE 1 TAB BY MOUTH EVERY DAY FOR 210 DAYS >> DO NOT CRUSH << Prescriber GELOK,CHRISTIAN,NP Rx#33321090 Order Date 06/26/15 Start Date Stop Date 01/22/16		New order
	CALCIUM CARB 1250MG/VIT D 1250 MG TABS ~OSCAL-D 500~ TAKE 1 TAB BY MOUTH EVERY DAY FOR 210 DAYS Prescriber GELOK,CHRISTIAN,NP Rx#33321092 Order Date 06/26/15 Start Date Stop Date 01/22/16		New order
SMH	**ESTRADIOL 2 MG TABS ~ESTRACE~** TAKE 2 TABS (4MG) BY MOUTH EVERY MORNING FOR 90 DAYS **APPROVED** Prescriber POULSON,WILLIAM NP Rx#34043389 Order Date 10/08/15 Start Date 10-8-15 Stop Date 01/06/16	A	[illegible initials, days 1–6] STOP
SMH	**FINASTERIDE 5 MG TABS ~PROSCAR~** TAKE 1 TAB BY MOUTH EVERY DAY FOR 90 DAYS **APPROVED** >>WOMEN OF CHILD BEARING AGE SHOULD NOT HANDLE THIS DRUG<< Prescriber BARRY,DANIEL C Rx#34183187 Order Date 11/05/15 Start Date 11-5-15 Stop Date 02/03/16	A	New order
	SPIRONOLACTONE 100 MG TABS ~ALDACTONE~ TAKE 1 TAB BY MOUTH TWICE DAILY FOR 210 DAYS >> MAY CAUSE DIZZINESS << Prescriber GELOK,CHRISTIAN,NP Rx#33321099 Order Date 06/26/15 Start Date Stop Date 01/22/16		New order
SMH	**VENLAFAXINE HCL XR 150 MG CP24 ~EFFEXOR XR~** TAKE 1 CAP BY MOUTH EACH MORNING FOR 120 DAYS >> DO NOT CRUSH; MAY CAUSE DROWSINESS << Prescriber SEYS,JANE,NP Rx#34266417 Order Date 11/20/15 Start Date 11-20-15 Stop Date 03/19/16	A	[illegible initials, days 1–26] 30 new order

Diagnosis:

Allergies: No Known Drug Allergy A-15

[redacted] 94691 DOB/Inmate #

6340- MAIN(00) Location: A16

Name: EDMO, MASON 1/23

Medication Administration Record

Documentation Codes	Staff Signature	Initials	Signature	Date	Staff Signature	Initials	Signature	Date	Staff Signature	Initials	Signature
	K. Barney, LPN	[illegible]	[illegible]	1-2016	~~R. Dibben, C N A~~			1-2016	C. Marria, LPN	[illegible]	[illegible]
D/C - Discontinued Order	M. Beck, RN	MB	[illegible]	1-2016	J. Drake, LPN	[illegible]	[illegible]	1-2016	~~T. Mccall, LPN~~		
	~~A. Bennett, LPN~~	[illegible]	[illegible]	1-2016	~~V. Ferro, LPN~~			1-2016	~~L. Moser, C N A~~		
R - Refused	A. Benton, ~~LPN~~ RN	[illegible]	[illegible]	1-2016	~~M. Gonzales, LPN~~			1-2016	A. Nisby, LPN	[illegible]	[illegible]
	A. Beshears, RN	[illegible]	[illegible]	1-2016	M. Grace, RN			1-2016	S. Patterson, LPN	[illegible]	[illegible]
A - Absent	~~G. Blackburn, LPN~~		[illegible]	1-2016	S. Harrod, MA	SmH	SHarrod	1-2016	S. Perus, LPN	[illegible]	[illegible]
	C. Brenenstahl, dialysis tech	[illegible]	[illegible]	1-2016	S. Hawk, LPN	SH	[illegible]	1-2016	~~H. Pierce, LPN~~		
O - Other	G. Brewer, RN	GB	[illegible]	1-2016	~~L. Hill, PhT~~	[illegible]	[illegible]	1-2016	A. Pope, C N A	[illegible]	[illegible]
	L. Brown, LPN	LB	[illegible]	1-2016	N. Hoffman, LPN	NH	[illegible]	1-2016	D. Rainier, LPN	[illegible]	[illegible]
	~~M. Bryant, RN~~			1-2016	N. Homme, LPN	NCH	[illegible]	1-2016	~~E. Reed, LPN~~		
	G. Capshaw, RN	[illegible]	[illegible]	1-2016	~~C. Hooper, CMS~~			1-2016	G. Rodriguez, LPN	[illegible]	[illegible]
	~~L. Carlson, RN DON~~			1-2016	A. Huddleston, C N A	[illegible]	[illegible]	1-2016	J. Savell, LPN	[illegible]	[illegible]
	T. Case, LPN	[illegible]	[illegible]	1-2016	D. Jensen, LPN	[illegible]	[illegible]	1-2016	~~C. Wilson C N A~~		
	P. Cleveland, MA	[illegible]	[illegible]	1-2016	K. Larsen, LPN	KL	[illegible]	1-2016	C. Wilson, LPN	[illegible]	[illegible]
	A. Cooper, MA	[illegible]	[illegible]	1-2016	T. Lee, RN	TL	[illegible]	1-2016	W. Wingert, RN, DON	[illegible]	[illegible]
	~~C. Curtis, LPN~~	CC	[illegible]	1-2016	~~S. Mallet, LPN~~	[illegible]	[illegible]	1-2016	N. Wise, RN	[illegible]	[illegible]
	S. Deeds, RN	SD	[illegible]	1-2016				1-2016	C. Young, LPN	[illegible]	[illegible]
				1-2016		DW	Dawn [illegible]	1-2016			

Date/Time	NOTES

MEDICATION ADMINISTRATION RECORD

Facility: 6340 Month: January 2016

Init	Drug - Dose - Mode - Interval	HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	Aldactone 125 mg Po BID X120 days Prescriber Poulson Order Date 12/23 Start Date 12/24 Stop Date 4/24/16	K																															
	ASA 81 mg po QD X 365 days Prescriber Poulson Order Date 12/23 Start Date 12/24 Stop Date 12/23/16	K																															
	Oscal D- 500mg Po QHS X 365 days Prescriber Poulson Order Date 12/23 Start Date 12/24 Stop Date 12/23/16	K																															
	Estradial 4 mg po QD X90 days Start 1-7-16 4-6-16 Prescriber Poulson 1-7-16 Order Date 12/23 Start Date 12/24 Stop Date 3/24/16	A																															
	Oscal 5 mg Po QD X90 days Prescriber Poulson Order Date 12/23 Start Date 12/29/15 Stop Date 3/28/16	A																															
	Remeron 7.5 mg PO @ HS Prescriber Scott Eliason, MD x120 days Order Date 1/27/16 Start Date 1/27/16 Stop Date 4/27/16	HS																															

Diagnosis:

Allergies: No Known Drug Allergy

94691 DOB/Inmate #:

6340 Location:

Edmo, Mason Name:

2/2 3

#3150 REV 4/10

ER 2122

MEDICATION ADMINISTRATION RECORD

Facility: **Month:**

Init.	Drug - Dose - Mode - Interval	HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
PE	Effexor XR 150mg PO q am Prescriber: Scott Eliason, MD x120 days Order Date 11/27/16 Start Date 4/27/16 Stop Date 4/27/16	A																															
	Prescriber Order Date Start Date Stop Date																																
	Prescriber Order Date Start Date Stop Date																																
	Prescriber Order Date Start Date Stop Date																																
	Prescriber Order Date Start Date Stop Date																																
	Prescriber Order Date Start Date Stop Date																																

Diagnosis:

Allergies:

DOB/Inmate #: 94691 Location: Name: Edma, Mason

3/3

#3150 REV 4/10

ER 2123

Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID **Month:** February 2016

Init.	Drug - Dose - Mode - Interval	HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	ASPIRIN EC 81 MG TBEC ~ECOTRIN ~ 1/25 TAKE 1 TAB BY MOUTH EVERY DAY FOR 12 MONTHS >> DO NOT CRUSH << #6 Prescriber POULSON,WILLIAM NP Rx#34454692 Order Date 12/23/15 Start Date 12/24/15 Stop Date 12/17/16	K O P																														
	CALCIUM CARB 1250MG/VIT D 1250 MG TABS ~OSCAL-D 500~ TAKE 1 TAB BY MOUTH AT BEDTIME FOR 12 MONTHS 1/25 #7 Prescriber POULSON,WILLIAM NP Rx#34454696 Order Date 12/23/15 Start Date 12/24/15 Stop Date 12/17/16	K O P																														
	ESTRADIOL 2 MG TABS ~ESTRACE~ 1/25 TAKE 2 TABS (4MG) BY MOUTH EACH MORNING FOR 90 DAYS #30 **APPROVED** Prescriber POULSON,WILLIAM NP Rx#34523670 Order Date 01/07/16 Start Date 1/7/16 Stop Date 04/06/16	K O P															^	V	V														
	FINASTERIDE 5 MG TABS ~PROSCAR~ 1/25 TAKE 1 TAB BY MOUTH DAILY FOR 90 DAYS **APPROVED** >>WOMEN OF CHILD BEARING AGE SHOULD NOT HANDLE THIS DRUG<< #12 Prescriber POULSON,WILLIAM NP Rx#34470096 Order Date 12/28/15 Start Date 12/24/15 Stop Date 03/27/16	~~AM~~ K O P		^ 7	V 30																												
	SPIRONOLACTONE 100 MG TABS ~ALDACTONE~ 1/25 TAKE 1 TAB BY MOUTH WITH 25MG TWICE DAILY FOR 120 DAYS (125MG TOTAL) >> MAY CAUSE DIZZINESS << #8 Prescriber POULSON,WILLIAM NP Rx#34454686 Order Date 12/23/15 Start Date 12/24/15 Stop Date 04/21/16	K O P															^	V	V														
	Remeron 7.5 mg po HS Prescriber Scott Eliasen, MD Rx 120 days Order Date 2/17/16 Start Date 2/17/16 Stop Date 6/17/16																																

Diagnosis: No Known Drug Allergy

Allergies:

94691 DOB/Inmate #:

6340- MAIN(00) Location:

EDMO, MASON Name:

PharmaCorr

#3150 REV 4/10

ER 2124

Medication Administration Record

Documentation Codes	Staff Signature	Date	Initials
K. Barney, LPN		2-2016	
M. Beck, RN		2-2016	
D/C - Discontinued Order	A. Bennett, LPN		2-2016
R - Refused	A. Benton, RN		2-2016
	A. Beshears, RN		2-2016
A - Absent	G. Blackburn, LPN		2-2016
O - Other	[redacted]		2-2016
	G. Brewer, RN		2-2016
	L. Brown, LPN		2-2016
	[redacted]		2-2016
	G. Capshaw, RN		2-2016
	L. Carlson, RN, DON		2-2016
	T. Case, LPN		2-2016
	P. Cleveland, MA		2-2016
	A. Cooper, MA		2-2016
	C. Curtis, LPN		2-2016
	[redacted]		2-2016
	B. Cash, RN	PSC	2-2016

Staff Signature	Date	Initials
R. Dibben, C N A	2-2016	
J. Drake, LPN	2-2016	
V. Ferro, LPN	2-2016	
[redacted]	2-2016	
M. Grace, RN	2-2016	
S. Harrod, MA	2-2016	
S. Hawk, LPN	2-2016	
L. Hill, PhT	2-2016	
N. Hoffman, LPN	2-2016	
N. Homme, LPN	2-2016	
C. Hoopes, CMS	2-2016	
A. Huddleston, C N A	2-2016	
D. Jensen, LPN	2-2016	
K. Larsen, LPN	2-2016	
T. Lee, RN	2-2016	
S. Mallet, LPN	2-2016	
B. Reece LPN	2-2016	
Choice Luster, CMS	2-2016	

Staff Signature	Date	Initials
C. Marria, LPN	2-2016	
T. Mccall, LPN	2-2016	
[redacted]	2-2016	
A. Nisby, LPN	2-2016	
S. Patterson, LPN	2-2016	
S. Perus, LPN	2-2015	
[redacted]	2-2015	
A. Pope, C N A	2-2015	
D. Rainier, LPN	2-2015	
E. Reed, LPN	2-2015	
G. Rodriguez, LPN	2-2015	
J. Savell, LPN	2-2015	
C. Wilson, LPN	2-2015	
[redacted]	2-2015	
W. Wingert, RN, DON	2-2016	
N. Wise, RN	2-2016	
[redacted]	2-2016	
L. Tice CNA	2-2016	
J. Bryant MA	2-2016	

Date/Time		NOTES
2/1/16	P	Absent SPA
2/2/16	P	Absent SPA
2-3-16	Ar	Absent
2/3/16	pm	Absent provider notified
2/4/16	pm	absent for pill cb
2/5/16	pm	Absent
2/6/16	pm	Absent
2/8/16	P	Refused SPA
2/9/16	P	Absent SPA
2/10/16	pm	Absent provider notified
2/11/16	pm	absent for pill cb
2/12/16	P	Absent SPA
2/13/16	P	Absent SPA Provider notified
2/14/16	pm	absent for pill cb

2/15/16 pm absent for pill cb
2/16/16 P Absent SPA

ER 2125

Pg.287
Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID **Month:** February 2016

Init.	Drug - Dose - Mode - Interval	HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	SPIRONOLACTONE 25 MG TABS ~ALDACTONE~ 1/25 TAKE 1 TAB BY MOUTH WITH 100MG TWICE DAILY FOR 120 DAYS (125MG TOTAL) >> MAY CAUSE DIZZINESS << #8 Prescriber POULSON,WILLIAM NP Rx#34454691 Order Date 12/23/15 Start Date Stop Date 04/21/16	K O P															^																
	VENLAFAXINE HCL XR 150 MG CP24 ~EFFEXOR XR~ KE 1 CAP BY MOUTH EACH MORNING FOR 120 DAYS >> DO NOT RUSH; MAY CAUSE DROWSINESS << Prescriber SEYS,JANE,NP Rx#34266417 Order Date 11/20/15 Start Date Stop Date 03/19/16			new Rx																													
	Effexor XR 150mg PO qAM Prescriber Scott Eliason, MD Order Date 1/27 Start Date 1/27 Stop Date 5/27	A																	1														
	Remeron 7.5mg PO qhs x120d Prescriber Scott Eliason, MD Order Date 1/27 Start Date 1/27 Stop Date 5/27																		STOP														
	Effexor XR 150mg PO qAM x120d Prescriber Scott Eliason, MD Order Date 1/27 Start Date 1/27 Stop Date 5/27																																
	Prescriber Order Date Start Date Stop Date																																

Diagnosis: No Known Drug Allergy
Allergies:

[redacted] 94691 DOB/Inmate #:

6340- MAIN(00) Location:

EDMO, MASON Name:

PharmaCorr

#3150 REV 4/10

ER 2126

Medication Administration Record

Documentation Codes	Staff Signature	Initials	Date
	K. Barney, LPN	KB	2-2016
	M. Beck, RN	MB	2-2016
D/C - Discontinued Order	A. Bennett, LPN		2-2016
R - Refused	A. Benton, RN		2-2016
	A. Beshears, RN		2-2016
A - Absent	G. Blackburn, LPN		2-2016
	[redacted]		2-2016
O - Other	G. Brewer, RN		2-2016
	L. Brown, LPN		2-2016
	[redacted]		2-2016
	G. Capshaw, RN		2-2016
	L. Carlson, RN, DON		2-2016
	T. Case, LPN		2-2016
	P. Cleveland, MA		2-2016
	A. Cooper, MA		2-2016
	C. Curtis, LPN		2-2016
	[redacted]		2-2016
	P. B. Cash, RN	PSC	2-2016

Staff Signature	Initials	Date
R. Dibben, C N A		2-2016
J. Drake, L N		2-2016
V. Ferro, LPN		2-2016
[redacted]		2-2016
M. Grace, RN		2-2016
S. Harrod, MA		2-2016
S. Hawk, LPN		2-2016
L. Hill, PhT		2-2016
N. Hoffman, LPN		2-2016
N. Homme, LPN		2-2016
C. Hoopes, CMS		2-2016
A. Huddleston, C N A		2-2016
D. Jensen, LPN		2-2016
K. Larsen, LPN		2-2016
T. Lee, RN		2-2016
S. Mallet, LPN		2-2016
B. Reece LPN		2-2016
Choice Luster, CMS		2-2016

Staff Signature	Initials	Date
C. Marria, LPN		2-2016
I. Mccall, LPN		2-2016
[redacted]		2-2016
A. Nisby, LPN		2-2016
S. Patterson, LPN		2-2016
S. Perus, LPN		2-2016
[redacted]		2-2016
A. Pope, C N A		2-2016
D. Rainier, LPN		2-2016
E. Reed, LPN		2-2016
G. Rodriguez, LPN		2-2016
J. Savell, LPN		2-2016
C. Wilson, LPN		2-2016
[redacted]		2-2016
W. Wingert, RN, DON		2-2016
N. Wise, RN		2-2016
[redacted]		2-2016
L Tice CNA	LT	2-2016
J Bryant CMA		2-2016

Date/Time	NOTES

ER 2127

Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID **Month:** April 2016

Init. | Drug - Dose - Mode - Interval | HR 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

ASPIRIN EC 81 MG TBEC ~ECOTRIN ~

TAKE 1 TAB BY MOUTH EVERY DAY FOR 12 MONTHS >> DO NOT CRUSH <<

Prescriber POULSON,WILLIAM NP Rx#34454692

Order Date 12/23/15 Start Date 12-23-15 Stop Date 12/17/16

CALCIUM CARB 1250MG/VIT D 1250 MG TABS ~OSCAL-D 500~

TAKE 1 TAB BY MOUTH AT BEDTIME FOR 12 MONTHS

Prescriber POULSON,WILLIAM NP Rx#34454696

Order Date 12/23/15 Start Date 12-23-15 Stop Date 12/17/16

ESTRADIOL 2 MG TABS ~ESTRACE~

TAKE 2 TABS (4MG) BY MOUTH EACH MORNING FOR 90 DAYS **APPROVED**

Prescriber POULSON,WILLIAM NP Rx#34523670

Order Date 01/07/16 Start Date 1-7-16 Stop Date 04/06/16

ESTRADIOL 2 MG TABS ~ESTRACE~

TAKE 2 TABS (4MG) BY MOUTH EACH MORNING **APPROVED**

Prescriber AGLER,DAVID,MD Rx#34959236

Order Date 04/07/16 Start Date 4-7-16 Stop Date 05/07/16

FINASTERIDE 5 MG TABS ~PROSCAR~

TAKE 1 TAB BY MOUTH DAILY FOR 90 DAYS **APPROVED** >>WOMEN OF CHILD BEARING AGE SHOULD NOT HANDLE THIS DRUG<<

Prescriber AGLER,DAVID,MD Rx#34959294

Order Date 03/28/16 Start Date 3-28-16 Stop Date 06/26/16

Prescriber

Order Date Start Date Stop Date

[redacted] 94691 6340- MAIN(00) EDMO, MASON

Diagnosis: No Known Drug Allergy

Allergies: DOB/Inmate #: Location: Name:

PharmaCorr

3150 REV 4/10

ER 2128

Medication Administration Record

Documentation Codes	Staff Signature	Date	Initials
	K. Barney, LPN		
	M. Beck, RN		
D/C - Discontinued Order	~~A. Bennett, LPN~~		
	A. Benton, RN, DON		
R - Refused	A. Beshears, RN		
	G. Blackburn, LPN		
A - Absent	C. Brenenstahl, dialysis tech		
	~~G. Brewer, RN, DON~~		
O - Other	L. Brown, LPN		
	~~M. Bryant, RN~~		
	G. Capshaw, RN		
	~~L. Carlson, RN~~		
	T. Case, LPN		
	P. J. Cash, RN		
	P. Cleveland, MA		
	A. Cooper, MA		
	C. Curtis, LPN		
	~~S. Deeds, RN~~		

Staff Signature	Date	Initials
R. Dibben, C N A		
J. Drake, LPN		
~~V. Ferro, LPN~~		
~~M. Gonzales, LPN~~		
M. Grace, RN		
S. Harrod, MA		
S. Hawk, LPN		
L. Hill, PhT		
N. Hoffman, LPN		
~~N. Homma, LPN~~		
C. Hoopes, CMS		
A. Huddleston, C N A		
D. Jensen, LPN		
K. Larsen, LPN		
T. Lee, RN		
C. Luster, CMS		
~~S. Mullet, LPN~~		
C. Tucker, RN		
L. Hayes, LPN		

Staff Signature	Date	Initials
C. Marria, LPN		
T. Mccall, LPN		
A. Nisby, LPN		
S. Patterson, LPN		
S. Perus, LPN		
H. Pierce, LPN		
A. Pope, C N A		
D. Rainier, LPN		
B. Reece, LPN		
G. Rodriguez, LPN		
J. Savell, LPN		
L. Tice, C N A		
~~M. Usog, MA~~		
T. Vaudrin MA		
C. Wilson, LPN		
~~D. Wison,~~		
~~W. Wingert, RN~~		
N. Wise, RN		
JBryant MA		

Date/Time	NOTES
3/31/16	Referral sent to CC to renew meds

Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID **Month:** April 2016

Init	Drug - Dose - Mode - Interval	HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	SPIRONOLACTONE 100 MG TABS ~ALDACTONE~ TAKE 1 TAB BY MOUTH WITH 25MG TWICE DAILY FOR 120 DAYS (125MG TOTAL) >> MAY CAUSE DIZZINESS << Prescriber POULSON,WILLIAM NP Rx#34454686 Order Date 12/23/15 Start Date 12-23-15 Stop Date 04/21/16														New order								STOP										
	SPIRONOLACTONE 25 MG TABS ~ALDACTONE~ TAKE 1 TAB BY MOUTH WITH 100MG TWICE DAILY FOR 120 DAYS (125MG TOTAL) >> MAY CAUSE DIZZINESS << Prescriber POULSON,WILLIAM NP Rx#34454691 Order Date 12/23/15 Start Date 12-23-15 Stop Date 04/21/16														New order								STOP										
	VENLAFAXINE HCL XR 150 MG CP24 ~EFFEXOR XR~ TAKE 1 CAP BY MOUTH EACH MORNING FOR 120 DAYS >> DO NOT CRUSH; MAY CAUSE DROWSINESS << Prescriber ELIASON,SCOTT PSY Rx#34656642 Order Date 01/28/16 Start Date 1-28-16 Stop Date 05/27/16																						NEW ORDER										
	ALDACTON 125mg PO BID x90days Prescriber Agler Order Date 4-5-16 Start Date 4-5-16 Stop Date 7-5-16								120 V																								
	Effexor XR 150 mg PO Qam x120 days Scott Eliason, MD Prescriber Order Date 4/20/16 Start Date 4/20/16 Stop Date 8/20/16																						30 V										
	Prescriber Order Date Start Date Stop Date																																

Diagnosis: No Known Drug Allergy

[redacted] 94691 6340- MAIN(00) EDMO, MASON

Allergies

93150 REV 4/10

PharmaCorr

ER 2130

Medication Administration Record

Documentation Codes	Staff Signature	Date	Initials
D/C - Discontinued Order	K. Barney, LPN		
R - Refused	M. Beck, RN		
A - Absent	~~A. Bennett, LPN~~		
O - Other	A. Benton, RN, DON		
	A. Beshears, RN		
	G. Blackburn, LPN		
	C. Brenenstahl, dialysis tech		
	~~G. Brewer, RN, DON~~		
	L. Brown, LPN		
	~~M. Bryant, RN~~		
	G. Capshaw, RN		
	~~L. Carlson, RN~~		
	T. Case, LPN		
	P. J. Cash, RN		
	P. Cleveland, MA		
	~~A. Cooper, MA~~		
	C. Curtis, LPN		
	~~S. Deeds, RN~~		

Staff Signature	Date	Initials
R. Dibben, C N A		
J. Drake, LPN		
~~V. Feeney, LPN~~		
~~M. Gonzales, LPN~~		
M. Grace, RN		
S. Harrod, MA		
S. Hawk, LPN		
L. Hill, PhT		
N. Hoffman, LPN		
~~N. Homme, LPN~~		
C. Hoopes, CMS		
A. Huddleston, C N A		
D. Jensen, LPN		
K. Larsen, LPN		
T. Lee, RN		
C. Luster, CMS		
~~S. Mallet, LPN~~		
C. Tucker, RN		
L. Hayes, LPN		

Staff Signature	Date	Initials
C. Marria, LPN		
T. Mccall, LPN		
A. Nisby, LPN		
S. Patterson, LPN		
~~S. Tenis, LPN~~		
H. Pierce, LPN		
A. Pope, C N A		
D. Rainier, LPN		
B. Reece, LPN		
G. Rodriguez, LPN		
J. Savell, LPN		
L. Tice, C N A		
~~M. Usog, MA~~		
T. Vaudrin MA		
C. Wilson, LPN		
D. Wison,		
~~W. Wright, RN~~		
N. Wise, RN		
J Bryant MA		

Date/Time	NOTES

ER 2131

Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID **Month:** May 2016

Init.	Drug - Dose - Mode - Interval	HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	ASPIRIN EC 81 MG TBEC ~ECOTRIN ~ TAKE 1 TAB BY MOUTH EVERY DAY FOR 12 MONTHS >> DO NOT CRUSH << Prescriber POULSON,WILLIAM NP Rx#34454692 Order Date 12/23/15 Start Date 12/23 Stop Date 12/17/16	A																														
	CALCIUM CARB 1250MG/VIT D 1250 MG TABS ~OSCAL-D 500~ TAKE 1 TAB BY MOUTH AT BEDTIME FOR 12 MONTHS Prescriber POULSON,WILLIAM NP Rx#34454696 Order Date 12/23/15 Start Date 12/23 Stop Date 12/17/16	P																														
	ESTRADIOL 2 MG TABS ~ESTRACE~ TAKE 2 TABS (4MG) BY MOUTH EACH MORNING **APPROVED** Prescriber AGLER,DAVID,MD Rx#34959236 Order Date 04/07/16 Start Date 4/7 Stop Date 05/07/16	A																														
	FINASTERIDE 5 MG TABS ~PROSCAR~ Top Drawer TAKE 1 TAB BY MOUTH DAILY FOR 90 DAYS **APPROVED** >>WOMEN OF CHILD BEARING AGE SHOULD NOT HANDLE THIS DRUG<< Prescriber AGLER,DAVID,MD Rx#34959294 Order Date 03/28/16 Start Date 3/28 Stop Date 06/26/16	A																														
	SPIRONOLACTONE 100 MG TABS ~ALDACTONE~ AKE 1 TAB BY MOUTH W/25MG TWICE DAILY FOR 90 DAYS >> MAY CAUSE DIZZINESS << Prescriber AGLER,DAVID,MD Rx#35078644 Order Date 04/06/16 Start Date 4/6 Stop Date 07/05/16	A																														
	SPIRONOLACTONE 25 MG TABS ~ALDACTONE~ TAKE 1 TAB BY MOUTH W/100MG TWICE DAILY FOR 90 DAYS >> MAY CAUSE DIZZINESS << Prescriber AGLER,DAVID,MD Rx#35078649 Order Date 04/06/16 Start Date 4/6 Stop Date 07/05/16	A																														
		P																														

[redacted] 94691 6340- MAIN(00) EDMO, MASON

Diagnosis:

No Known Drug Allergy

Allergies: DOB/Inmate #: Location: Name:

#3150 REV 4/10

Pharmacy

ER 2132

Medication Administration Record

Documentation Codes	Staff Signature	Date	Initials	Staff Signature	Date	Initials
	K. Barney, LPN		J. Drake, LPN		C. Marria, LPN	
	~~M. Beck, RN~~		V. Ferro, LPN		T. Mccall, LPN	
D/C - Discontinued Order	A. Bennett, LPN		~~M. Gonzalez, LPN~~		A. Nisby, LPN	
R - Refused	A. Benton, RN, DON		~~M. Grace, RN~~		S. Patterson, LPN	
	A. Beshears, RN		S. Harrod, MA		S. Perus, LPN	
A - Absent	~~G. Blackburn, LPN~~		S. Hawk, LPN		H. Pierce, LPN	
	C. Brenenstahl, dialysis tech		~~L. Hayes, LPN~~		~~A. Pope, C N A~~	
O - Other	~~G. Brewer, RN, DON~~		L. Hill, PhT		~~D. Rainier, LPN~~	
	L. Brown, LPN		~~N. Hoffman, LPN~~ N. Hoffman LPN		B. Reece, LPN	
	J. Bryant, MA		N. Homme, LPN		G. Rodriguez, LPN	
	~~M. Bryant, RN~~		C. Hoopes, CMS		J. Savell, LPN	
	~~G. Capshaw, RN~~		~~A. Huddleston, C N A~~		L. Tice, C N A	
	T. Case, LPN		D. Jensen, LPN		~~C. Tucker, RN~~	
	~~P. J. Cash, RN~~		K. Larsen, LPN		M. Usog, MA	
	P. Cleveland, MA		T. Lee, RN		~~T. Vaudrin MA~~	
	A. Cooper, MA		C. Luster, CMS		C. Wilson, LPN	
	C. Curtis, LPN		S. Mallet, LPN		~~B. Wilson,~~	
	S. Deeds, RN		A Huddleston CNA		~~N. Wise, RN~~	
					T. Buckles, RN	

Date/Time	NOTES

ER 2133

Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID **Month:** May 2016

Init	Drug - Dose - Mode - Interval	HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	VENLAFAXINE HCL XR 150 MG CP24 ~EFFEXOR XR~ TAKE 1 CAP BY MOUTH EACH MORNING FOR 120 DAYS >> DO NOT CRUSH; MAY CAUSE DROWSINESS << Prescriber ELIASON,SCOTT PSY Rx#35164385 Order Date 04/20/16 Start Date 4/20 Stop Date 08/18/16	A																														
	Estrace 4mg po QAM x90days Prescriber Hafer Order Date 5/5 Start Date 5/6 Stop Date 8/16/16	A					→																									
	Prescriber Order Date Start Date Stop Date																															
	Prescriber Order Date Start Date Stop Date																															
	Prescriber Order Date Start Date Stop Date																															
	Prescriber Order Date Start Date Stop Date																															

Diagnosis:

No Known Drug Allergy

Allergies:

[redacted] 94691 6340- MAIN(00) N/V EDMO, MASON

DOB/Inmate #: Location: Name:

3150 REV 4/10

ER 2134

Medication Administration Record

Documentation Codes	Staff Signature	Date	Initials
	K. Barney, LPN		
	~~M. Beck, RN~~		
D/C - Discontinued Order	A. Bennett, LPN		
R - Refused	A. Benton, RN, DON		
	A. Beshears, RN		
A - Absent	~~G. Blackburn, LPN~~		
	C. Brenenstahl, dialysis tech		
O - Other	G. Brewer, RN, DON		
	L. Brown, LPN		
	J. Bryant, MA		
	~~M. Bryant, RN~~		
	~~G. Capshaw, RN~~		
	T. Case, LPN		
	~~P. J. Cash, RN~~		
	P. Cleveland, MA		
	A. Cooper, MA		
	C. Curtis, LPN		
	S. Deeds, RN		

Staff Signature	Date	Initials
J. Drake, LPN		
V. Ferro, LPN		
~~M. Gonzales, LPN~~		
~~M. Grace, RN~~		
S. Harrod, MA		
S. Hawk, LPN		
~~L. Hayes, LPN~~		
L. Hill, PhT		
~~N. Hoffman, LPN~~		
N. Homme, LPN		
C. Hoopes, CMS		
~~A. Huddleston, CNA~~		
D. Jensen, LPN		
K. Larsen, LPN		
T. Lee, RN		
C. Luster, CMS		
S. Mallet, LPN		
A Huddleston CNA		

Staff Signature	Date	Initials
C. Marria, LPN		
T. Mccall, LPN		
A. Nisby, LPN		
S. Patterson, LPN		
S. Perus, LPN		
H. Pierce, LPN		
~~A. Pope, C N A~~		
D. Rainier, LPN		
B. Reece, LPN		
G. Rodriguez, LPN		
J. Savell, LPN		
L. Tice, C N A		
~~C. Tucker, RN~~		
M. Usog, MA		
~~T. Vaudrin MA~~		
C. Wilson, LPN		
~~D. Wilson,~~		
~~N. Wise, RN~~		
J. Buckles, RN		

Date/Time	NOTES
4/28	Sent Referral to CDP PC
5/26/16	IEP - ABSENT

ER 2135

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID **Month:** June 2016

Init.	Drug - Dose - Mode - Interval	HR	Days 1–31
	ASPIRIN EC 81 MG TBEC ~ECOTRIN ~ TAKE 1 TAB BY MOUTH EVERY DAY FOR 12 MONTHS >> DO NOT CRUSH << Prescriber POULSON,WILLIAM NP Rx#34454692 Order Date 12/23/15 Start Date 12-23-15 Stop Date 12/17/16	A	[handwritten initials, days 1–30; day 14: V 30]
	CALCIUM CARB 1250MG/VIT D 1250 MG TABS ~OSCAL-D 500~ TAKE 1 TAB BY MOUTH AT BEDTIME FOR 12 MONTHS Prescriber POULSON,WILLIAM NP Rx#34454696 Order Date 12/23/15 Start Date 12-23-15 Stop Date 12/17/16	P	[handwritten initials, days 1–30; day 7: 30; day 9: 9]
	ESTRADIOL 2 MG TABS ~ESTRACE~ TAKE 2 TABS BY MOUTH DAILY FOR 90 DAYS **APPROVED** Prescriber AGLER,DAVID,MD Rx#35257718 Order Date 05/05/16 Start Date 05-05-16 Stop Date 08/03/16	A	[handwritten initials, days 1–30]
	FINASTERIDE 5 MG TABS ~PROSCAR~ TAKE 1 TAB BY MOUTH DAILY FOR 90 DAYS **APPROVED** >>WOMEN OF CHILD BEARING AGE SHOULD NOT HANDLE THIS DRUG<< Prescriber AGLER,DAVID,MD Rx#34959294 Order Date 03/28/16 Start Date 03-28-15 Stop Date 06/26/16	A	[handwritten initials, days 1–26; day 7: 30; days 27–30: STOP new order]
	SPIRONOLACTONE 100 MG TABS ~ALDACTONE~ TAKE 1 TAB BY MOUTH W/25MG TWICE DAILY FOR 90 DAYS >> MAY CAUSE DIZZINESS << Prescriber AGLER,DAVID,MD Rx#35078644 Order Date 04/06/16 Start Date 04-06-16 Stop Date 07/05/16	A P	[handwritten initials, days 1–30; day 9: V 60; day 9: 9]
	Proscar 5mg po qday x 90 days Prescriber Agler Order Date 6·27 Start Date 6·27 Stop Date 9·2016	A	[line drawn to day 27] written MAR

Diagnosis: No Known Drug Allergy

Allergies:

[redacted] 94691 (DOB/Inmate #) 6340- (Location) MAIN(00) EDMO, MASON (Name) 1/2

PharmaCorr

#3150 REV 4/10

Medication Administration Record

Documentation Codes	Staff Signature	Date	Initials	Staff Signature	Date	Initials
K. Barney, LPN		6-2016	J. Drake, LPN		6-2016	C. Marria, LPN		6-2016	
M. Beck, RN		6-2016	~~V. Forro, LPN~~		6-2016	T. Mccall, LPN		6-2016	
A. Benton, RN, DON		6-2016	~~M. Gonzales, LPN~~		6-2016	S. Patterson, LPN		6-2016	
A. Beshears, RN		6-2016	~~M. Grace, RN~~		6-2016	S. Perus, LPN		6-2016	
~~C. Blackburn, LPN~~		6-2016	S. Harrod, MA		6-2016	H. Pierce, LPN		6-2016	
C. Brenenstahl, dialysis tech		6-2016	S. Hawk, LPN		6-2016	A. Pope, C N A		6-2016	
G. Brewer, RN, DON		6-2016	~~E. Hayes, LPN~~		6-2016	D. Rainier, LPN		6-2016	
L. Brown, LPN		6-2016	L. Hill, PhT		6-2016	B. Reece, LPN		6-2016	
L. Bryant, MA		6-2016	~~N. Hoffman, LPN~~ N. Homme, LPN		6-2016	G. Rodriguez, LPN		6-2016	
M. Bryant, RN		6-2016	N. Homme, LPN		6-2016	J. Savell, LPN		6-2016	
C. Capshaw, RN		6-2016	C. Hoopes, CMS		6-2016	L. Tice, C N A		6-2016	
T. Case, LPN		6-2016	A. Huddleston, C N A		6-2016	~~S. Tucker, RN~~		6-2016	
P. J. Cash, RN		6-2016	D. Jensen, LPN		6-2016	M. Usog, MA		6-2016	
~~L. Chou, LPN~~		6-2016	K. Larsen, LPN		6-2016	T. Vaudrin MA		6-2016	
P. Cleveland, MA		6-2016	T. Lee, RN		6-2016	C. Wilson, LPN		6-2016	
A. Cooper, MA		6-2016	C. Luster, CMS		6-2016	~~B. Wilson, C N A~~		6-2016	
~~C. Curtis, LPN~~		6-2016	S. Mallet, LPN		6-2016	~~M. Wise, RN~~		6-2016	
~~G. Deeds, RN~~		6-2016	Veronica Ferro LPN		6-2016	E. ZHOU LPN		6-2016	
Eileen Mitchell, RN		6-2016			6-2016			6-2016	

D/C - Discontinued Order
A - Absent
O - Other

Date/Time	NOTES
6.5.16.	Am absent x2

ER 2137

Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID **Month:** June 2016

Init	Drug - Dose - Mode - Interval	HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	SPIRONOLACTONE 25 MG TABS ~ALDACTONE~ TAKE 1 TAB BY MOUTH W/100MG TWICE DAILY FOR 90 DAYS >> MAY CAUSE DIZZINESS << Prescriber AGLER,DAVID,MD Rx#35078649 Order Date 04/06/16 Start Date 04-06-16 Stop Date 07/05/16	A																															
		P																														
	VENLAFAXINE HCL XR 150 MG CP24 ~EFFEXOR XR~ TAKE 1 CAP BY MOUTH EACH MORNING FOR 120 DAYS >> DO NOT CRUSH; MAY CAUSE DROWSINESS << Prescriber ELIASON,SCOTT PSY Rx#35164385 Order Date 04/20/16 Start Date 04-20-16 Stop Date 08/18/16	A																															
	Prozac 5mg po qd x 90days Prescriber Agler Order Date 6-27-16 Start Date 6-27-16 Stop Date 9-27-16	A																															
	Prescriber Order Date Start Date Stop Date																																
	Prescriber Order Date Start Date Stop Date																																
	Prescriber Order Date Start Date Stop Date																																

[redacted] 94691 6340- MAIN(00) **EDMO, MASON** 2/2

Diagnosis: No Known Drug Allergy

Allergies: DOB/Inmate #: Location: Name:

#3150 REV 4/10 PharmaCorr

ER 2138

Medication Administration Record

Documentation Codes	Staff Signature	Date	Initials	Staff Signature	Date	Initials
K. Barney, LPN		6-2016	J. Drake, LPN		6-2016	C. Marria, LPN		6-2016	
M. Beck, RN		6-2016	V. Ferro, LPN		6-2016	T. Mccall, LPN		6-2016	
D/C - Discontinued Order									
A. Benton, RN, DON		6-2016	M. Gonzalez, LPN		6-2016	S. Patterson, LPN		6-2016	
A. Bestbears, RN		6-2016	M. Grace, RN		6-2016	S. Perus, LPN		6-2016	
G. Blackburn, LPN		6-2016	S. Harrod, MA		6-2016	H. Pierce, LPN		6-2016	
A - Absent									
C. Brenenstahl, dialysis tech		6-2016	S. Hawk, LPN		6-2016	A. Pope, C N A		6-2016	
G. Brewer, RN, DON		6-2016	L. Hayes, LPN		6-2016	D. Rainier, LPN		2016	
O - Other									
L own, LPN		6-2016	L. Hill, PHT		6-2016	B. Reece, LPN		6-2016	
J yant, MA		6-2016	N. Hoffman, LPN		6-2016	G. Rodriguez, LPN		6-2016	
M Bryant, RN		6-2016	N. Homme, LPN		6-2016	J. Savell, LPN		6-2016	
G apshaw, RN		6-2016	C. Hoopes, CMS		6-2016	L. Tice, C N A		6-2016	
T. Case, LPN		6-2016	A. Huddleston, C N A		6-2016	S. Tucker, RN		6-2016	
P. J. Cash, RN		6-2016	D. Jensen, LPN		6-2016	M. Usog, MA		6-2016	
E. Chou, LPN		6-2016	K. Larsen, LPN		6-2016	T. Vaudrin MA		6-2016	
P. Cleveland, MA		6-2016	T. Lee, RN		6-2016	C. Wilson, LPN		6-2016	
A. Cooper, MA		6-2016	C. Luster, CMS		6-2016	D. Wilson, C N A		6-2016	
C. Curtis, LPN		6-2016	S. Mallet, LPN		6-2016	N. Wise, RN		6-2016	
S. Deeds, RN		6-2016	Veronica Ferro LPN		6-2016	E. ZHOU LPN		6-2016	
Eileen Mitchell, RN		6-2016			6-2016			6-2016	

Date/Time	NOTES
5/5/2016 AM	R/S Referral sent to renew meds absent X2

Pg:273
Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M **6340-** IDAHO STATE CORR INST (ISCI) ID **Month:** July 2016

Init	Drug - Dose - Mode - Interval	HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	VENLAFAXINE HCL XR 150 MG CP24 ~EFFEXOR XR~ TAKE 1 CAP BY MOUTH EACH MORNING FOR 120 DAYS >> DO NOT CRUSH; MAY CAUSE DROWSINESS << Prescriber ELIASON,SCOTT PSY Rx#35164385 Order Date 04/20/16 Start Date 4/20 Stop Date 08/18/16	A	M	T	AC START																											NEW ORD
	Spironolactone 125mg BID x 90 days P.O. Prescriber Barry Order Date 7-6-16 Start Date 7-6-16 Stop Date 10-5-16	AM / PM					→																									
B	Effexor XR 225mg PO QAM x 120 days Prescriber Seys Order Date 7.28.16 Start Date 7.29.16 Stop Date 11.26.16	A																													
	Prescriber Order Date Start Date Stop Date																														
	Prescriber Order Date Start Date Stop Date																														
	Prescriber Order Date Start Date Stop Date																														

[redacted] **94691** 6340- MAIN(00) **EDMO, MASON** 2/2

Diagnosis: No Known Drug Allergy

Allergies:

DOB/Inmate #: Location: Name:

PharmaCorr

#3150 REV 4/10

ER 2140

Medication Administration Record

Documentation Codes	Staff Signature	Date	Initials	Staff Signature	Date	Initials
K. Barney, LPN		7-2016		T. Mccall, LPN	7-2016	
M. Beck, RN		7-2016		E. Mitchell, RN	7-2016	
A. Benton, RN, DON		7-2016		S. Patterson, LPN	7-2016	
A. Beshears, RN		7-2016		S. Perus, LPN	7-2016	
C. Blackburn, LPN		7-2016	S. Harrod, MA	H. Pierce, LPN	7-2016	
C. Brenenstahl, dialysis tech		7-2016		A. Pope, CNA	7-2016	
G. Brewer, RN, DON		7-2016	L. Hill, PhT	D. Rainier, LPN	7-2016	
L. Brown, LPN		7-2016		P. Reece, LPN	7-2016	
L. Bryant, MA		7-2016	N. Homme, LPN	G. Rodriguez, LPN	7-2016	
M. Bryant, RN		7-2016		J. Savell, LPN	7-2016	
S. Stapleton, RN		7-2016	A. Huddleston, CNA	L. Tice, CNA	7-2016	
T. Case, LPN	TC	7-2016	D. Jensen, LPN	G. Tucker, RN	7-2016	
P. J. Cash, RN	PJC	7-2016	K. Larsen, LPN	M. Usog, MA	7-2016	
P. Cleveland, MA		7-2016	T. Lee, RN	T. Vaudrin, MA	7-2016	
A. Cooper, MA		7-2016	C. Luster, CMS	G. Wilson, LPN	7-2016	
C. Curtis, LPN		7-2016	S. Mallet, LPN	D. Wilson, CNA	7-2016	
J. Jarrett, LPN		7-2016	C. Marria, LPN	N. Wise, RN	7-2016	
		7-2016		S. Zhou, LPN	7-2016	
		7-2016			7-2016	

D/C - Discontinued Order
A - Absent
O - Other

Date/Time		NOTES
7/3		Referral Sent R
7/5/16	pm	Absent R
7/6/16	pm	Referral pull to
7/6/16	pm	Absent R
7/26	A	I'm informed of Stop date for Estrogen R

ER 2141

Pg:272
Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID **Month:** July 2016

Init.	Drug - Dose - Mode - Interval	HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	ASPIRIN EC 81 MG TBEC ~ECOTRIN ~ TAKE 1 TAB BY MOUTH EVERY DAY FOR 12 MONTHS >> DO NOT CRUSH << Prescriber POULSON,WILLIAM NP Rx#34454692 Order Date 12/23/15 Start Date 12/23 Stop Date 12/17/16																																
	CALCIUM CARB 1250MG/VIT D 1250 MG TABS ~OSCAL-D 500~ TAKE 1 TAB BY MOUTH AT BEDTIME FOR 12 MONTHS Prescriber POULSON,WILLIAM NP Rx#34454696 Order Date 12/23/15 Start Date 12/23 Stop Date 12/17/16																																
	ESTRADIOL 2 MG TABS ~ESTRACE~ TAKE 2 TABS BY MOUTH DAILY FOR 90 DAYS **APPROVED** Prescriber AGLER,DAVID,MD Rx#35257718 Order Date 05/05/16 Start Date 5/5 Stop Date 08/03/16																																
	SPIRONOLACTONE 100 MG TABS ~ALDACTONE~ TAKE 1 TAB BY MOUTH W/25MG TWICE DAILY FOR 90 DAYS >> MAY CAUSE DIZZINESS << Prescriber AGLER,DAVID,MD Rx#35078644 Order Date 04/06/16 Start Date 4/6 Stop Date 07/05/16																																
	SPIRONOLACTONE 25 MG TABS ~ALDACTONE~ TAKE 1 TAB BY MOUTH W/100MG TWICE DAILY FOR 90 DAYS >> MAY CAUSE DIZZINESS << Prescriber AGLER,DAVID,MD Rx#35078649 Order Date 04/06/16 Start Date 4/6 Stop Date 07/05/16																																
SMH	Proscar 5mg po QDay x90 days Prescriber Agler Order Date 6.27 Start Date 6.27 Stop Date 9.27.16																																

Diagnosis: No Known Drug Allergy

Allergies:

[redacted] 94691 DOB/Inmate #:

6340- MAIN(00) Location: C54

EDMO, MASON 1/2 Name:

PharmaCorr

#3150 REV 4/10

ER 2142

Medication Administration Record

Documentation Codes	Staff Signature	Date	Initials	Staff Signature	Date	Initials
K. Barney, LPN		7-2016		T. Mccall, LPN	7-2016	
M. Beck, RN		7-2016		[redacted]	7-2016	
D/C - Discontinued Order						
A. Benton, RN, DON				S. Patterson, LPN		
A. Beshears, RN		-2016		S. Perus, LPN	7-2016	
R - Refused						
[redacted]		7-2016	S. Harrod, MA	H. Pierce, LPN	7-2016	
C. Brenenstahl, dialysis tech		7-2016		[redacted]	7-2016	
A - Absent						
G. Brewer, RN, DON		7-2016	L. Hill, PhT	[redacted]	7-2016	
O - Other						
L. Brown, LPN		7-2016		B. Reece, LPN	7-2016	
[redacted]		7-2016	N. Homme, LPN	G. Rodriguez, LPN	7-2016	
[redacted]		7-2016		J. Savell, LPN	7-2016	
[redacted]		7-2016	A. Huddleston, C N A	L. Tice, C N A	7-2016	
T. Case, LPN		7-2016	D. Jensen, LPN	[redacted]	7-2016	
P. J. Cash, RN		7-2016	K. Larsen, LPN	M. Usog, MA	7-2016	
P. Cleveland, MA		7-2016	T. Lee, RN	T. Vaudrin MA	7-2016	
A. Cooper, MA		7-2016	C. Luster, CMS	[redacted]	7-2016	
C. Curtis, LPN		7-2016	S. Mallet, LPN	D. Wilson, C N A	7-2016	
J. Jarrett, LPN			C. Marria, LPN	[redacted]	7-2016	
		7-2016			7-2016	
		7-2016			7-2016	

Date/Time	NOTES
7/6/16 pm	Absent DBC

ER 2143

Form: H6/31

MEDICATION ADMINISTRATION RECORD

M 6340- IDAHO STATE CORR INST (ISCI) ID August 2016

Facility: **Month:**

Ini. Drug - Dose - Mode - Interval | HR | 1 2 | 3 4 | 5 6 | 7 8 | 9 10 | 11 12 | 13 14 | 15 16 | 17 18 | 19 20 | 21 22 | 23 24 | 25 26 | 27 28 | 29 30 | 31

ASPIRIN EC 81 MG TBEC ~ECOTRIN~

TAKE 1 TAB BY MOUTH EVERY DAY FOR 12 MONTHS >> DO NOT CRUSH <<

Prescriber POULSON,WILLIAM NP Rx#34454692

Order Date 12/23/15 Start Date 12-23-15 Stop Date 12/17/16

CALCIUM CARB 1250MG/VIT D 1250 MG TABS ~OSCAL D 500~

TAKE 1 TAB BY MOUTH AT BEDTIME FOR 12 MONTHS

Prescriber POULSON,WILLIAM NP Rx#34454696

Order Date 12/23/15 Start Date 12-23-15 Stop Date 12/17/16

ESTRADIOL 2 MG TABS ~ESTRACE~

TAKE 2 TABS BY MOUTH DAILY FOR 90 DAYS **APPROVED**

NEW ORDER

Prescriber AGLER,DAVID,MD Rx#35257718

Order Date 05/05/16 Start Date 5-5-16 Stop Date 08/03/16

FINASTERIDE 5 MG TABS ~PROSCAR~ TOP DRAWER

TAKE 1 TAB BY MOUTH EVERY DAY FOR 90 DAYS **APPROVED** >>WOMEN OF CHILD BEARING AGE SHOULD NOT HANDLE THIS DRUG<<

Prescriber AGLER,DAVID,MD Rx#35683554

Order Date 06/27/16 Start Date 6-27-16 Stop Date 09/25/16

NEW ORDER

SPIRONOLACTONE 100 MG TABS ~ALDACTONE~

TAKE 1 TAB BY MOUTH TWICE DAILY (WITH 25MG) FOR 90 DAYS >> MAY CAUSE DIZZINESS <<

Prescriber BARRY,DANIEL C Rx#35755403

Order Date 07/07/16 Start Date 7-7-16 Stop Date 10/05/16

SPIRONOLACTONE 25 MG TABS ~ALDACTONE~

TAKE 1 TAB BY MOUTH TWICE DAILY (WITH 100MG) FOR 90 DAYS >> MAY CAUSE DIZZINESS <<

Prescriber BARRY,DANIEL C Rx#35755405

Order Date 07/07/16 Start Date 7-7-16 Stop Date 10/05/16

[redacted] 94691 6340- MAIN(00) EDMO, MASON 1/2

Diagnosis: No Known Drug Allergy

Allergies: DOB/Inmate #: Location: XXX Name:

#3130 REV 4/10 PharmaCorr

ER 2144

Medication Administration Record

Documentation Codes	Staff Signature	Date	Initials	Staff Signature	Date	Initials
	K. Barney, LPN	8-2016		V. Ferro, LPN	8-2016	
D/C - Discontinued Order	M. Beck, RN	8-2016		~~M. Gonzales, LPN~~	8-2016	
	~~A. Benton, RN, DON~~	8-2016		~~M. Grace, RN~~	8-2016	
R - Refused	A. Beshears, RN	8-2016		S. Harrod, MA	8-2016	
	G. Blackburn, LPN	8-2016		S. Hawk, LPN	8-2016	
A - Absent	C. Brenenstahl, dialysis tech	8-2016		L. Hill, PhT	8-2016	
O - Other	G. Brewer, RN, DON	8-2016		N. Hoffman, LPN	8-2016	
	~~L. Brown, LPN~~	8-2016		~~N. Homme, LPN~~	8-2016	
	J. Bryant, MA	8-2016		C. Hoopes, CMS	8-2016	
	~~M. Bryant, RN~~	8-2016		A. Huddleston, C N A	8-2016	
	G. Capshaw, RN	8-2016		J. Jarrett, LPN	8-2016	
	T. Case, LPN	8-2016		D. Jensen, LPN	8-2016	
	P. J. Cash, RN	8-2016		K. Larsen, LPN	8-2016	
	P. Cleveland, MA	8-2016		T. Lee, RN	8-2016	
	A. Cooper, MA	8-2016		C. Luster, CMS	8-2016	
	C. Curtis, LPN	8-2016		S. Mallet, LPN	8-2016	
	J. Drake, LPN	8-2016		C. Marria, LPN	8-2016	
	L. Eagle, RN	8-2016		T. Mccall, LPN	8-2016	
	J. Buckles, RN	8-2016		M. Harper, LPN	8-2016	
	M. Chavez, MA					

Staff Signature	Date	Initials
E. Mitchell, RN	8-2016	
S. Patterson, LPN	8-2016	
~~S. Perus, LPN~~		
H. Pierce, LPN	8-2016	
A. Pope, C N A	8-2016	
D. Rainier, LPN	8-2016	
B. Reece, LPN	8-2016	
~~G. Rodriguez, LPN~~	8-2016	
J. Savell, LPN	8-2016	
B. Smith, C N A	8-2016	
L. Tice, C N A	8-2016	
~~C. Tucker, RN~~	8-2016	
~~M. Usog, MA~~	8-2016	
T. Vaudrin MA	8-2016	
~~C. Wilson, LPN~~	8-2016	
D. Wilson, C N A	8-2016	
N. Wise, RN	8-2016	
E. Zhou, LPN	8-2016	
H. Taff	8-2015	

NOTES

Date/Time	
8:12 AM	Absent-m
8/13/16 PM	absent BG rid G

Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID **Month:** August 2016

Init.	Drug - Dose - Mode - Interval	HR	1 2	3 4	5 6	7 8	9 10	11 12	13 14	15 16	17 18	19 20	21 22	23 24	25 26	27 28	29 30	31
	~~VENLAFAXINE HCL XR 150 MG CP24 ~EFFEXOR XR~~ TAKE 1 CAP BY MOUTH EACH MORNING FOR 120 DAYS >> DO NOT CRUSH; MAY CAUSE DROWSINESS << Prescriber ELIASON,SCOTT PSY Rx#35164385 Order Date 04/20/16 Start Date Stop Date 08/18/16		NEW ORDER									STOP						
IB	Effexor XR 225mg PO QAM x120 days Prescriber Seys Order Date 7.28.16 Start Date 7.29.16 Stop Date 11.26.16	A	90												90			
IB	Estradiol 4mg PO Q day x90 days NF Prescriber Dellwo *approved Order Date 8.1.16 Start Date 8.3.16 Stop Date 11.1.16	A	→			^	60 (2mg)											
IB	Proscar 5mg PO QAM x90 days NF Prescriber Sweetser Order Date 8.26.16 Start Date 8.30.16 Stop Date 11.28.16	A	→															30
	Prescriber Order Date Start Date Stop Date																	
	Prescriber Order Date Start Date Stop Date																	

Diagnosis: No Known Drug Allergy

Allergies:

[redacted] 94691 DOB/Inmate #:

6340- Location: MAIN(00)

EDMO, MASON Name: 2/2

#3150 REV 4/10

ER 2146

Medication Administration Record

Documentation Codes	Staff Signature	Initials / Signature	Date	Staff Signature	Initials / Signature	Date	Staff Signature	Initials / Signature	Date
	K. Barney, LPN	[signature]	2016	V. Ferro, LPN	[signature]	8-2016	E. Mitchell, RN	[signature]	8-2016
D/C - Discontinued Order	M. Beck, RN	[signature]	8-2016	~~M. Gonzales, LPN~~		8-2016	S. Patterson, LPN	[signature]	8-2016
	A. Benton, RN, DON	[signature]	8-2016	M. Grace, RN	MG [signature]	8-2016	S. Perus, LPN	[signature]	8-2016
R - Refused	A. Beshears, RN	[signature]	8-2016	S. Harrod, MA	SMH [signature]	8-2016	H. Pierce, LPN	[signature]	8-2016
	G. Blackburn, LPN	[signature]	8-2016	S. Hawk, LPN	[signature]	8-2016	A. Pope, C N A	[signature]	8-2016
A - Absent	C. Brenenstahl, dialysis tech	[signature]	8-2016	L. Hill, PhT	[signature]	2016	D. Rainier, LPN	[signature]	2016
	G. Brewer, RN, DON	[signature]	8-2016	N. Hoffman, LPN	[signature]	2016	B. Reece, LPN	[signature]	8-2016
O - Other	L. Brown, LPN	[signature]	8-2016	N. Homme, LPN	[signature]	2016	G. Rodriguez, LPN	[signature]	8-2016
	J. Bryant, MA	[signature]	8-2016	C. Hoopes, CMS	[signature]	8-2016	J. Savell, LPN	[signature]	2016
	~~M. Bryant, RN~~		2016	A. Huddleston, C N A	[signature]	2016	B. Smith, C N A	[signature]	2016
	G. Capshaw, RN	[signature]	8-2016	J. Jarrett, LPN	[signature]	2016	L. Tice, C N A	LT [signature]	8-2016
	T. Case, LPN	TC [signature]	2016	D. Jensen, LPN	[signature]	2016	~~G. Tucker, RN~~		8-2016
	~~P. J. Cash, RN~~	PJC [signature]	2016	~~K. Larsen, LPN~~	[signature]	2016	~~M. Usog, MA~~	[signature]	2016
	P. Cleveland, MA	PC [signature]		T. Lee RN	[signature]	8-2016	T. Vaudrin MA	[signature]	8-2016
	A. Cooper, MA	AC [signature]	8-2016	C. Luster, CMS	CEL [signature]	8-2016	~~C. Wilson, LPN~~		8-2016
	~~C. Curtis, LPN~~	CC [signature]		~~S. Mallet, LPN~~	[signature]	2016	~~D. Wilson, C N A~~	[signature]	2016
	J. Drake, LPN	[signature]	8-2016	C. Marria, LPN	[signature]	2016	N. Wise, RN	NW [signature]	8-2016
	L. Eagle, RN	[signature]	8-2016	T. Mccall, LPN	[signature]	2016	E. Zhou, LPN	XZ [signature]	8-2016
	J. Buckles, RN	[signature]		M. Harper, LPN	[signature]		H. Taff	[signature]	8-2016
	M. Chavez, MA	M [signature]							

NOTES [signature] J. LPN

Date/Time		Notes
7/25/16	A	Ifm informed of stop date for estrogen
7-30	A	Referral sent to CC for estrace - M
8-4-16	PM	Absent [signature]
8/11/16 - Absent		
8-12	AM	Absent - M
8.12.16 PM		Absent for pill pass DW
8/13/16	AM	absent for pill pass
8/23/16	PM	absent for pill pass

ER 2147

Form: H6/31

MEDICATION ADMINISTRATION RECORD

M 6340- IDAHO STATE CORR INST (ISCI) ID September 2016

Facility: **Month:**

Int	Drug - Dose - Mode - Interval	HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	~~ASPIRIN EC 81 MG TBEC ~ECOTRIN~~	AM																															
	TAKE 1 TAB BY MOUTH EVERY DAY FOR 12 MONTHS >> DO NOT CRUSH <<																																
	Prescriber POULSON,WILLIAM NP Rx#34454692																																
17	Order Date 12/23/15 Start Date 12/23/15 Stop Date 12/17/16																																
	~~CALCIUM CARB 1250MG/VIT D 1250 MG TABS ~OSCAL-D 500~~																																
	TAKE 1 TAB BY MOUTH AT BEDTIME FOR 12 MONTHS																																
	Prescriber POULSON,WILLIAM NP Rx#34454696																																
17	Order Date 12/23/15 Start Date 12/23/15 Stop Date 12/17/16																																
	~~ESTRADIOL 2 MG TABS ~ESTRACE~~	AM																															
	TAKE 2 TABS BY MOUTH DAILY FOR 90 DAYS **APPROVED**																																
	Prescriber DELLWO,DANIEL PA Rx#35939218																																
17	Order Date 08/02/16 Start Date 8/3/16 Stop Date 10/31/16																																
	~~FINASTERIDE 5 MG TABS ~PROSCAR~~	AM																										STOP					
	TAKE 1 TAB BY MOUTH EVERY DAY FOR 90 DAYS **APPROVED** >>WOMEN OF CHILD BEARING AGE SHOULD NOT HANDLE THIS DRUG<<																																
	Prescriber AGLER,DAVID,MD Rx#35683554																																
17	Order Date 06/27/16 Start Date 9/27/16 Stop Date 09/25/16																																
	~~SPIRONOLACTONE 100 MG TABS ~ALDACTONE~~	AM																															
	TAKE 1 TAB BY MOUTH TWICE DAILY (WITH 25MG) FOR 90 DAYS >> MAY CAUSE DIZZINESS <<																																
	Prescriber BARRY,DANIEL C Rx#35755403																																
17	Order Date 07/07/16 Start Date 7/7/16 Stop Date 10/05/16																																
	~~SPIRONOLACTONE 25 MG TABS ~ALDACTONE~~	AM																															
	TAKE 1 TAB BY MOUTH TWICE DAILY (WITH 100MG) FOR 90 DAYS >> MAY CAUSE DIZZINESS <<																																
	Prescriber BARRY,DANIEL C Rx#35755405																																
17	Order Date 07/07/16 Start Date 7/7/16 Stop Date 10/05/16																																

[redacted]

Diagnosis: No Known Drug Allergy

Allergies:

94691 DOB/Inmate #:

6340- MAIN(00) EDMO, MASON Location: C54 Name:

1/2

PharmaCorr

#0130 REV 9/18

ER 2148

Medication Administration Record

Documentation Codes	Staff Signature	Date	Initials	Staff Signature	Date	Initials
D/C - Discontinued Order	~~K. Barney, LPN~~			~~L. Eagle, RN~~		
R - Refused	M. Beck, RN			V. Ferro, LPN		
A - Absent	A. Benton, RN, DON			~~M. Grace, RN~~		
O - Other	A. Beshears, RN			~~M. Harper, RN~~		
	~~G. Blackburn, LPN~~			S. Harrod, MA		
	C. Brenenstahl, dialysis tech			S. Hawk, LPN		
	G. Brewer, RN, DON			L. Hill, PhT		
	L. Brown, LPN			~~N. Hoffman, LPN~~		
	~~J. Buckles, RN~~			N. Homme, LPN		
	J. Bryant, MA			C. Hoopes, CMS		
	~~C. Capehorn, RN~~			A. Huddleston, C N A		
	T. Case, LPN			J. Jarrett, LPN		
	P. J. Cash, RN			D. Jensen, LPN		
	M. Chavez, MA			K. Larsen, LPN		
	P. Cleveland, MA			~~T. Lee, RN~~		
	A. Cooper, MA			C. Luster, CMS		
	C. Curtis, LPN			S. Mallet, LPN		
	J. Drake, LPN			C. Marria, LPN		
				~~James Hecht, LPN~~		

Staff Signature	Date	Initials
T. Mccall, LPN		
~~E. Mitchell, RN~~		
S. Patterson, LPN		
S. Perus, LPN		
~~H. Pierce, LPN~~		
A. Pope, C N A		
D. Rainier, LPN		
B. Reece, LPN		
G. Rodriguez, LPN		
J. Savell, LPN		
B. Smith, C N A		
~~H. Taff,~~		
L. Tice, C N A		
T. Vaudrin MA		
C. Wilson, LPN		
D. Wilson, C N A		
N. Wise, RN		
E. Zhou, LPN		

Date/Time	NOTES
9-1-16 AM ~~absent~~ PM ~~absent~~	was dosed in a holding cell in building 16 DS
	9-19 Late entry for ~~9-18~~ 9-18 inmate was in holding and was dosed all night meds DW
9-24 Absent for pill pass	
9-27 Absent for pill pass	DW
9-29-16 HS absent	

ER 2149

Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID Month: September 2016

Init.	Drug - Dose - Mode - Interval	HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	~~VENLAFAXINE HCL XR 75 MG CP24 -EFFEXOR XR-~~ TAKE 3 CAPS (225MG) BY MOUTH EACH MORNING FOR 120 DAYS >> DO NOT CRUSH; MAY CAUSE DROWSINESS << Prescriber SEYS,JANE,NP Rx#35905477 Order Date 07/28/16 Start Date 7/29/16 Stop Date 11/25/16	AM																															
17																									80 V								
VR	Proscar 5mg PO QAm x 90 days NF Prescriber Sweetser Order Date 8.26.16 Start Date 8.30.16 Stop Date 11.28.16	A																															
													NEW ORDER																				
VB	Estradiol 6mg PO Q day x90 days NF Prescriber Agler Order Date 9.8.16 Start Date 9.9.16 Stop Date 12.8.16	A							→																				90 V				
VS	Proscar 5mg PO Q day x 90 days NF Finasteride Prescriber Agler Order Date 9.8.16 Start Date 9.9.16 Stop Date 12.8.16	A							→																60 V								
VL	Aldactone 125 mg PO BID x1year Spironolactone Prescriber Agler Order Date 9.8.16 Start Date 9.9.16 Stop Date 9.8.17	A							→		60																						
		P							→																								
	Prescriber Order Date Start Date Stop Date																																

Diagnosis: No Known Drug Allergy

Allergies:

[redacted] 94691 DOB/Inmate #:

6340- Location:

MAIN(00) Name: EDMO, MASON

2/2

#3150 REV 4/10

PharmaCon

ER 2150

Medication Administration Record

Documentation Codes	Staff Signature	Date	Initials	Staff Signature	Date	Initials
~~K. Barnes, LPN~~		9-2016	~~L. Eagle, RN~~		9-2016	T. Mccall, LPN
M. Beck, RN		9-2016	V. Ferro, LPN		9-2016	~~E. Mitchell, RN~~
D/C - Discontinued Order			~~M. Grace, RN~~			S. Patterson, LPN
A. Beshears, RN		9-2016	~~M. Harper, RN~~		9-2016	S. Perus, LPN
R - Refused						
~~G. Blackburn, LPN~~		9-2016	S. Harrod, MA		9-2016	~~H. Pierce, LPN~~
A - Absent						
C. Brenenstahl, dialysis tech		9-2016	S. Hawk, LPN		9-2016	A. Pope, C N A
O - Other						
G. Brewer, RN, DON		9-2016	L. Hill, PhT		9-2016	D. Rainier, LPN
L. Brown, LPN		9-2016	~~N. Hoffman, LPN~~		9-2016	B. Reece, LPN
~~J. Buckles, RN~~		9-2016	N. Homme, LPN		9-2016	G. Rodriguez, LPN
J. Bryant, MA		9-2016	C. Hoopes, CMS		9-2016	J. Savell, LPN
~~C. Capehart, RN~~		9-2016	A. Huddleston, C N A		9-2016	B. Smith, C N A
T. Case, LPN		9-2016	J. Jarrett, LPN		9-2016	~~H. Taff,~~
P. J. Cash, RN		9-2016	D. Jensen, LPN		9-2016	L. Tice, C N A
M. Chavez, MA		9-2016	K. Larsen, LPN		9-2016	T. Vaudrin MA
P. Cleveland, MA		9-2016	~~T. Lee, RN~~		9-2016	C. Wilson, LPN
A. Cooper, MA		9-2016	C. Luster, CMS		9-2016	D. Wilson, C N A
C. Curtis, LPN		9-2016	S. Mallet, LPN		9-2016	N. Wise, RN
J. Drake, LPN		9-2016	C. Marria, LPN		9-2016	E. Zhou, LPN
		9-2016	James Hecht, LPN		9-2016	

Date/Time	NOTES
8/25/16	Referred to CDP to renew MPDS-17
9.1.16	Am absent x2 was dose in holding cell in building 16 RT
9-19	Late entry for 9-18 ~~inmate~~ in holding was dosed all night med sz
9.20.16	Absent for pill pass
9.21.16	Absent for pill pass
9-29-16	HB absent

ER 2151

Pg:282
Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID **Month:** October 2016

Init.	Drug - Dose - Mode - Interval	HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
M	SPIRONOLACTONE 25 MG TABS ~ALDACTONE~ TAKE 1 TAB (WITH 100MG) BY MOUTH TWICE DAILY FOR 12 MONTHS >> MAY CAUSE DIZZINESS << Prescriber AGLER,DAVID,MD Rx#36201117 Order Date 09/08/16 Start Date 9-9-16 Stop Date 09/03/17	A																														
M	VENLAFAXINE HCL XR 75 MG CP24 ~EFFEXOR XR~ TAKE 3 CAPS (225MG) BY MOUTH EACH MORNING FOR 120 DAYS >> DO NOT CRUSH; MAY CAUSE DROWSINESS << Prescriber SEYS,JANE,NP Rx#35905477 Order Date 07/28/16 Start Date 7-29-16 Stop Date 11/25/16	A																							NEW ORDER							
M	Estradiol vemg PO QD x90 days Prescriber Agler Order Date 9-8-16 Start Date 9-9-16 Stop Date 12-8-16	A																					90										
BC	Effexor XR 300 mg PO Q am x90 days Jane Seys, PNP Prescriber Order Date 10/20/16 Start Date 10/21/16 Stop Date 1/20/17	A																															
	Prescriber Order Date Start Date Stop Date																																
	Prescriber Order Date Start Date Stop Date																																

94691 6340- MAIN(00) EDMO, MASON

Diagnosis: No Known Drug Allergy

Allergies: DOB/Inmate #: Location: Name:

PharmaCorr

#3150 REV 4/10

ER 2152

ER 2153

Medication Administration Record

Documentation Codes	Staff Signature	Date	Initials
K. Barney, LPN		10-2016	
M. Beck, RN		10-2016	
A. Benton, RN, DON		10-2016	
A. Beshears, RN		10-2016	
~~G. Blackburn, LPN~~			
C. Brenenstahl, dialysis tech		10-2016	
G. Brewer, RN, DON		10-2016	
~~L. Brown, LPN~~		10-2016	
J. Buckles, RN		10-2016	
J. Bryant, MA		10-2016	
G. Capshaw, RN		10-2016	
T. Case, LPN		10-2016	
P. J. Cash, RN		10-2016	
M. Chavez, MA		10-2016	
P. Cleveland, MA		10-2016	
A. Cooper, MA		10-2016	
C. Curtis, LPN		10-2016	
J. Drake, LPN		10-2016	
		10-2016	

Staff Signature	Date	Initials
L. Eagle, RN	10-2016	
V. Ferro, LPN	10-2016	
~~M. Harper, RN LPN~~	10-2016	
S. Harrod, MA	10-2016	
S. Hawk, LPN	10-2016	
L. Hill, PhT	10-2016	
N. Hoffman, LPN	10-2016	
~~N. Homme~~, LPN	10-2016	
C. Hoopes, CMS	10-2016	
A. Huddleston, C N A	10-2016	
~~J. Jarrett, LPN~~	10-2016	
~~J. Jarvis, C N A~~ MA	10-2016	
D. Jensen, LPN	10-2016	
K. Larsen, LPN	10-2016	
T. Lee, RN	10-2016	
C. Luster, CMS	10-2016	
S. Mallet, LPN	10-2016	
C. Marria, LPN	10-2016	
J. Medvit LPN	10-2016	

Staff Signature	Date	Initials
T. Mccall, LPN	10-2016	
~~E. Mitchell, RN~~	10-2016	
~~S. Patterson, LPN~~	10-2016	
S. Perus, LPN	10-2016	
H. Pierce, LPN	10-2016	
~~A. Pope, C N A~~	10-2016	
D. Rainier, LPN	10-2016	
B. Reece, LPN	10-2016	
~~G. Rodriguez, LPN~~	10-2016	
J. Savell, LPN	10-2016	
B. Smith, C N A	10-2016	
H. Taff,	10-2016	
L. Tice, C N A	10-2016	
T. Vaudrin MA	10-2016	
C. Wilson, LPN	10-2016	
~~D. Wilson, C N A~~	10-2016	
N. Wise, RN	10-2016	
E. Zhou, LPN	10-2016	
Britnie Byington, LPN	10-2016	

Date/Time	NOTES
10-2-16 PM Absent	
10-4-16 PM Absent	
10.5.16 Absent for pill pass	
10-7-16 PM Absent	
10-11-16 PM absent	
10.14 HM Absent	
10/17/16 pm Absent for pill pass	
10/18 PM absent	
10-25 PM absent	
10-28 PM Absent	
10-31 PM absent	

Pg:281
Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID **Month:** October 2016

Int.	Drug - Dose - Mode - Interval	HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
M	**ASPIRIN EC 81 MG TBEC ~ECOTRIN~** TAKE 1 TAB BY MOUTH EVERY DAY FOR 12 MONTHS >> DO NOT CRUSH << Prescriber POULSON,WILLIAM NP Rx#34454692 Order Date 12/23/15 Start Date 12-24-15 Stop Date 12/17/16	A											30																			
M	**CALCIUM CARB 1250MG/VIT D 1250 MG TABS ~OSCAL-D 500~** TAKE 1 TAB BY MOUTH AT BEDTIME FOR 12 MONTHS Prescriber POULSON,WILLIAM NP Rx#34454696 Order Date 12/23/15 Start Date 12-24-15 Stop Date 12/17/16	P											30																			
	ESTRADIOL 2 MG TABS ~ESTRACE~ TAKE 2 TABS BY MOUTH DAILY FOR 90 DAYS **APPROVED** **NEW ORDER** Prescriber DELLWO,DANIEL PA Rx#35939218 Order Date 08/02/16 Start Date Stop Date 10/31/16																																
M	**FINASTERIDE 5 MG TABS ~PROSCAR~** TAKE 1 TAB BY MOUTH EVERY DAY FOR 90 DAYS **APPROVED** >>WOMEN OF CHILD BEARING AGE SHOULD NOT HANDLE THIS DRUG<< Prescriber SWEETSER,MATTHEW Rx#36134956 Order Date 08/30/16 Start Date 8-31-16 Stop Date 11/28/16	A																					30										
M	**SPIRONOLACTONE 100 MG TABS ~ALDACTONE~** TAKE 1 TAB (WITH 25MG) BY MOUTH TWICE DAILY FOR 12 MONTHS >> MAY CAUSE DIZZINESS << Prescriber AGLER,DAVID,MD Rx#36201111 Order Date 09/08/16 Start Date 9-9-16 Stop Date 09/03/17	A				60																											60
	Prescriber Order Date Start Date Stop Date	P																															

[redacted] 94691 6340- MAIN(00) **EDMO, MASON**

Diagnosis: No Known Drug Allergy

Allergies: DOB/Inmate #: Location: Name:

PharmaCorr

#3150 REV 4/10

ER 2154

Medication Administration Record

Documentation Codes	Staff Signature	Date	Staff Signature	Date	Staff Signature	Date
	K. Barney, LPN	10-2016	L. Eagle, RN	10-2016	T. Mccall, LPN	10-2016
D/C - Discontinued Order	M. Beck, RN	10-2016	V. Ferro, LPN	10-2016	~~E. Mitchell, RN~~	10-2016
	~~A. Benton, RN, DON~~	10-2016	~~M. Harper, RN LPN~~	10-2016	S. Patterson, LPN	10-2016
R - Refused	A. Beshears, RN	10-2016	S. Harrod, MA	10-2016	S. Perus, LPN	10-2016
	~~G. Blackburn, LPN~~	10-2016	S. Hawk, LPN	10-2016	H. Pierce, LPN	10-2016
A - Absent	C. Brenenstahl, dialysis tech	10-2016	L. Hill, PhT	10-2016	~~A. Pope, C N A~~	10-2016
O - Other	G. Brewer, RN, DON	10-2016	N. Hoffman, LPN	10-2016	D. Rainier, LPN	10-2016
	~~L. Brown, LPN~~	10-2016	~~N. Hemme, LPN~~	10-2016	~~B. Reece, LPN~~	10-2016
	J. Buckles, RN	10-2016	C. Hoopes, CMS	10-2016	~~G. Rodriguez, LPN~~	10-2016
	J. Bryant, MA	10-2016	A. Huddleston, C N A	10-2016	J. Savell, LPN	10-2016
	G. Capshaw, RN	10-2016	~~J. Jarrett, LPN~~	10-2016	B. Smith, C N A	10-2016
	T. Case, LPN	10-2016	J. Jarvis, ~~C N A~~ MA	10-2016	H. Taff,	10-2016
	P. J. Cash, RN	10-2016	D. Jensen, LPN	10-2016	L. Tice, C N A	10-2016
	M. Chavez, MA	10-2016	K. Larsen, LPN	10-2016	T. Vaudrin MA	10-2016
	P. Cleveland, MA	10-2016	T. Lee, RN	10-2016	C. Wilson, LPN	10-2016
	A. Cooper, MA	10-2016	C. Luster, CMS	10-2016	~~D. Wilson, C N A~~	10-2016
	C. Curtis, LPN	10-2016	S. Mallet, LPN	10-2016	N. Wise, RN	10-2016
	J. Drake, LPN	10-2016	C. Marria, LPN	10-2016	E. Zhou, LPN	10-2016
	J Farley LPN	10-2016	J Decker LPN	10-2016	Brittnie [illegible] LPN	10-2016

NOTES

Date/Time	
10-4-16 PM	late entry 10-2-16 PM Absent
10-4-16 PM	Absent
10.5.16 P	Absent for pill pass
10-11-16	PM absent
10.14	AM Absent
10/17/16 pm	Absent for pill pass BB
10/18 P	absent
10.25 P	Absent
10/31 P	Absent

Pg:278
Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID **Month:** November 2016

Init. Drug - Dose - Mode - Interval — HR 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

ASPIRIN EC 81 MG TBEC ~ECOTRIN~

TAKE 1 TAB BY MOUTH EVERY DAY FOR 12 MONTHS >> DO NOT CRUSH <<

Prescriber POULSON,WILLIAM NP Rx#34454692

Order Date 12/23/15 Start Date 12.24.16 Stop Date 12/17/16

CALCIUM CARB 1250MG/VIT D 1250 MG TABS ~OSCAL-D 500~

TAKE 1 TAB BY MOUTH AT BEDTIME FOR 12 MONTHS

Prescriber POULSON,WILLIAM NP Rx#34454696

Order Date 12/23/15 Start Date 12.24.16 Stop Date 12/17/16

ESTRADIOL 2 MG TABS ~ESTRACE~

TAKE 3 TABS (6MG) BY MOUTH EVERY DAY FOR 90 DAYS **APPROVED**

Prescriber AGLER,DAVID,MD Rx#36322303

Order Date 9/8/16 Start Date 9.08.16 Stop Date 12/8/16

FINASTERIDE 5 MG TABS ~PROSCAR~

TAKE 1 TAB BY MOUTH EVERY DAY FOR 90 DAYS >>WOMEN OF CHILD BEARING AGE SHOULD NOT HANDLE THIS DRUG<<

Prescriber AGLER,DAVID,MD Rx#36322283

Order Date 09/08/16 Start Date 9.8.16 Stop Date 12/08/16

SPIRONOLACTONE 100 MG TABS ~ALDACTONE~

TAKE 1 TAB (WITH 25MG) BY MOUTH TWICE DAILY FOR 12 MONTHS >> MAY CAUSE DIZZINESS <<

Prescriber AGLER,DAVID,MD Rx#36201111

Order Date 09/08/16 Start Date 9.9.16 Stop Date 09/03/17

SPIRONOLACTONE 25 MG TABS ~ALDACTONE~

TAKE 1 TAB (WITH 100MG) BY MOUTH TWICE DAILY FOR 12 MONTHS >> MAY CAUSE DIZZINESS <<

Prescriber AGLER,DAVID,MD Rx#36201117

Order Date 09/08/16 Start Date 9.9.16 Stop Date 09/03/17

[redacted] **94691** 6340- MAIN(00) **EDMO, MASON** 1/2

Diagnosis:

No Known Drug Allergy

Allergies:

DOB/Inmate #: Location: Name:

150 REV 4/10

Pharmacy

ER 2156

Pg:2/6
Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID **Month:** November 2016

Init	Drug - Dose - Mode - Interval	HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	ASPIRIN EC 81 MG TBEC ~ECOTRIN~ TAKE 1 TAB BY MOUTH EVERY DAY FOR 12 MONTHS >> DO NOT CRUSH << Prescriber POULSON,WILLIAM NP Rx#34454692 Order Date 12/23/15 Start Date 12.24.16 Stop Date 12/17/16																																
	CALCIUM CARB 1250MG/VIT D 1250 MG TABS ~OSCAL-D 500~ TAKE 1 TAB BY MOUTH AT BEDTIME FOR 12 MONTHS Prescriber POULSON,WILLIAM NP Rx#34454696 Order Date 12/23/15 Start Date 12.24.15 Stop Date 12/17/16																																
	ESTRADIOL 2 MG TABS ~ESTRACE~ TAKE 3 TABS (6MG) BY MOUTH EVERY DAY FOR 90 DAYS **APPROVED** Prescriber AGLER,DAVID,MD Rx#36322303 Order Date 9/8/16 Start Date 9.08.16 Stop Date 12/8/16																																
	FINASTERIDE 5 MG TABS ~PROSCAR~ TAKE 1 TAB BY MOUTH EVERY DAY FOR 90 DAYS >>WOMEN OF CHILD BEARING AGE SHOULD NOT HANDLE THIS DRUG<< Prescriber AGLER,DAVID,MD Rx#36322283 Order Date 09/08/16 Start Date 9.8.16 Stop Date 12/08/16																																
	SPIRONOLACTONE 100 MG TABS ~ALDACTONE~ AKE 1 TAB (WITH 25MG) BY MOUTH TWICE DAILY FOR 12 MONTHS >> MAY CAUSE DIZZINESS << Prescriber AGLER,DAVID,MD Rx#36201111 Order Date 09/08/16 Start Date 9.9.16 Stop Date 09/03/17																																
	SPIRONOLACTONE 25 MG TABS ~ALDACTONE~ TAKE 1 TAB (WITH 100MG) BY MOUTH TWICE DAILY FOR 12 MONTHS >> MAY CAUSE DIZZINESS << Prescriber AGLER,DAVID,MD Rx#36201117 Order Date 09/08/16 Start Date 9.9.16 Stop Date 09/03/17																																

[redacted] 94691 6340- MAIN(00) **EDMO, MASON** 1/2

Diagnosis:

No Known Drug Allergy

Allergies: DOB/Inmate #: Location: Name:

8015D REV 4/10 PharmaCorr

ER 2157

Medication Administration Record

Documentation Codes	Staff Signature	Initials	Date	Staff Signature	Initials	Date	Staff Signature	Initials	Date
	K. Barney, LPN	KB	11-2016	L. Eagle, RN		11-2016	T. Mccall, LPN		11-2016
D/C - Discontinued Order	M. Beck, RN	MB	11-2016	J. Farley, LPN		11-2016	E. Mitchell, RN	EM	11-2016
	A. Benton, RN, DON	AB	11-2016	~~V. Ferro, LPN~~		11-2016	S. Patterson, LPN		11-2016
R - Refused	A. Beshears, RN	AB	11-2016	~~M. Harper, RN~~		11-2016	S. Perus, LPN		11-2016
	~~G. Blackburn, LPN~~		11-2016	S. Harrod, MA		11-2016	~~H. Pierce, LPN~~		11-2016
A - Absent	~~C. Brenenstahl, dialysis tech~~		11-2016	S. Hawk, LPN		11-2016	A. Pope, C N A		11-2016
O - Other	G. Brewer, RN, DON	GB	11-2016	J. Hecht, LPN		11-2016	D. Rainier, LPN		11-2016
	~~L. Brown, LPN~~		11-2016	~~L. Hill, PhT~~	LH	11-2016	~~B. Reece, LPN~~		11-2016
	J. Buckles, RN		11-2016	N. Hoffman, LPN	NH	11-2016	G. Rodriguez, LPN		11-2016
	J. Bryant, MA	JB	11-2016	~~N. Homme, LPN~~	NCH	11-2016	~~J. Savell, LPN~~		11-2016
	~~G. Capshaw, RN~~		11-2016	~~C. Hoopes, CMS~~		11-2016	B. Smith, C N A	BS	11-2016
	T. Case, LPN	TC	11-2016	A. Huddleston, C N A		11-2016	~~H. Taff,~~		11-2016
	~~P. J. Cash, RN~~	PJC	11-2016	~~E. Jarvis, MA~~		11-2016	~~L. Tice, C N A~~		11-2016
	M. Chavez, MA		11-2016	D. Jensen, LPN		11-2016	T. Vaudrin MA	TV	11-2016
	P. Cleveland, MA	PC	11-2016	K. Larsen, LPN	KL	11-2016	C. Wilson, LPN		11-2016
	~~A. Cooper, MA~~		11-2016	~~T. Lee, RN~~		11-2016	~~D. Wilson, C N A~~		11-2016
	C. Curtis, LPN	CC	11-2016	C. Luster, CMS	CEL	11-2016	N. Wise, RN	NW	11-2016
	J. Drake, LPN		11-2016	~~S. Mallet, LPN~~		11-2016	E. Zhou, LPN	XZ	11-2016
	[illegible]		11-2016	C. Marria, LPN		11-2016	M. Jimenez, RN		11-2016
	Jared Berryman, CMS	JB		Britnie Byington, LPN	BB		J. Ferro, LPN		

Date/Time	NOTES
11-1-16 Am	absent SmH
11-9 Am	Absent - M Absent for pill pass BB
11-16-16 Am	
11-18-16 Am	absent SmH
11.24.16 Am	absent XZ

Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID **Month:** November 2016

Init.	Drug - Dose - Mode - Interval	HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	VENLAFAXINE HCL XR 150 MG CP24 ~EFFEXOR XR~ TAKE 2 CAPS (300MG) BY MOUTH EACH MORNING FOR 90 DAYS >> DO NOT CRUSH; MAY CAUSE DROWSINESS << Prescriber SEYS,JANE,NP Rx#36498379 Order Date 10/20/16 Start Date 10-21-16 Stop Date 01/18/17																																
	Prescriber Order Date Start Date Stop Date																																
	Prescriber Order Date Start Date Stop Date																																
	Prescriber Order Date Start Date Stop Date																																
	Prescriber Order Date Start Date Stop Date																																
	Prescriber Order Date Start Date Stop Date																																

Diagnosis:

No Known Drug Allergy

Allergies:

[redacted] 94691 6340- MAIN(00) EDMO, MASON 2/2

DOB/Inmate #: Location: Name:

#3150 REV 4/10

PharmaCorr

ER 2159

ER 2160

Medication Administration Record

Documentation Codes	Staff Signature	Date	Initials	Staff Signature	Date	Initials
K. Barney, LPN		11-2016	L. Eagle, RN		11-2016	T. Mccall, LPN
M. Beck, RN		11-2016	J. Farley, LPN		11-2016	E. Mitchell, RN
D/C - Discontinued — A. Benton, RN, DON		11-2016	~~V. Ferro, LPN~~		11-2016	S. Patterson, LPN
A. Beshears, RN		11-2016	~~M. Harper, RN~~		11-2016	S. Perus, LPN
R - Refused — ~~C. Blackburn, LPN~~		11-2016	S. Harrod, MA		11-2016	H. Pierce, LPN
A - Absent — ~~C. Brent, renal dialysis tech~~		11-2016	S. Hawk, LPN		11-2016	A. Pope, C N A
O - Other — G. Brewer, RN, DON		11-2016	J. Hecht, LPN		11-2016	D. Rainier, LPN
~~L. Brown, LPN~~		11-2016	~~L. Hill, PhT~~		11-2016	B. Reece, LPN
J. Buckles, RN		11-2016	N. Hoffman, LPN		11-2016	G. Rodriguez, LPN
J. Bryant, MA		11-2016	N. Homme, LPN		11-2016	J. Savell, LPN
~~G. Capshaw, RN~~		11-2016	~~G. Hoopes, CMS~~		11-2016	B. Smith, C N A
T. Case, LPN		11-2016	A. Huddleston, C N A		11-2016	~~H. Taff,~~
~~P. J. Cash, RN~~		11-2016	E. Jarvis, MA		11-2016	~~L. Tice, C N A~~
M. Chavez, MA		11-2016	D. Jensen, LPN		11-2016	T. Vaudrin MA
P. Cleveland, MA		11-2016	K. Larsen, LPN		11-2016	C. Wilson, LPN
A. Cooper, MA		11-2016	T. Lee, RN		11-2016	D. Wilson, C N A
C. Curtis, LPN		11-2016	C. Luster, CMS		11-2016	N. Wise, RN
J. Drake, LPN		11-2016	~~S. Mallet, LPN~~		11-2016	E. Zhou, LPN
~~[illegible], LPN~~		11-2016	C. Marria, LPN		11-2016	M. Jimenez, RN

Date/Time	Jared Berryman, CMS JLB	Britnie Byington, LPN BB	NOTES
11-1-16	Am absent SMH		
11-3	P absent SP		
11-9	AM	Absent-M Absent for pill pass	
11-16-16	AM		
11-16	P absent SP		
11-18-16	Am absent SMH		
11-20-16	PM Absent SP		
11-21-16	PM Absent SP		
11-22-16	PM Absent - Prat. notified - SP		
11-24-16	Am absent SP		
11-27-16	PM Absent		
11-28-16	PM Absent		

Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID

Month: December 2016

Init.	Drug - Dose - Mode - Interval	HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
SMH	SPIRONOLACTONE 25 MG TABS ~ALDACTONE~ TAKE 1 TAB (WITH 100MG) BY MOUTH TWICE DAILY FOR 12 MONTHS >> MAY CAUSE DIZZINESS << Prescriber AGLER,DAVID,MD Rx#36201117 Order Date 09/08/16 Start Date 9.9.16 Stop Date 09/03/17	A	SMH				SMH																						new order				
SMH	VENLAFAXINE HCL XR 150 MG CP24 ~EFFEXOR XR~ TAKE 2 CAPS (300MG) BY MOUTH EACH MORNING FOR 90 DAYS >> DO NOT CRUSH; MAY CAUSE DROWSINESS << Prescriber SEYS,JANE,NP Rx#36498379 Order Date 10/20/16 Start Date 10.21.16 Stop Date 01/18/17	A	SMH				SMH																					SMH	SMH				
VS	Estrace 6mg PO daily X90 days start 12.8.16 NF ★approved Prescriber Dellwo Order Date 11.29.16 Start Date 12.8.16 Stop Date 3.8.17	A	→																									new order				
VS ✓	Proscar 5mg PO daily X90 days NF ★approved Prescriber Dellwo Order Date 11.29.16 Start Date 12.3.16 Stop Date 3.3.17	A	→				SMH																					SMH	SMH				
	Prescriber Order Date Start Date Stop Date:																																
	Prescriber Order Date Start Date Stop Date:																																

[redacted] 94691 6340- MAIN(00) EDMO, MASON 2/3

Diagnosis: No Known Drug Allergy

Allergies: DOB/Inmate #: Location: Name:

PharmaCorr

#3150 REV 4/10

ER 2161

Medication Administration Record

Documentation Codes	Staff Signature		Date	Initials	Staff Signature		Date	Initials
	K. Barney, LPN		12-2016	J. Drake, LPN		12-2016	T. Mccall, LPN	
	~~J. Barryman, CMS~~		12-2016	L. Eagle, RN		12-2016	E. Mitchell, RN	12-20 6
D/C - Discontinued Order	~~M. Beck, RN~~		12-201	V. Ferro, LPN			S. Patterson, LPN	12-20 6
R - Refused	A. Benton, RN, DON		12-2016	S. Harrod, MA			S. Perus, LPN	12-20 6
	A. Beshears, RN			S. Hawk, LPN		12-2016	~~H. Pierce, LPN~~	
A - Absent	G. Blackburn, LPN		12-2016	L. Hill, PhT		12-2016	A. Pope, C N A	12-20 6
	C. Brenenstahl, dialysis tech		12-2016	~~N. Hoffman, LPN~~		12-2016	D. Rainier, LPN	12-20 6
O - Other	~~G. Brewer, RN, DON~~		12-2016	~~N. Homme, LPN~~		12-2016	B. Reece, LPN	12-20 6
	L. Brown, LPN		12-2016	C. Hoopes, CMS		12-2016	G. Rodriguez, LPN	12-20 6
	J. Bryant, MA		12-2016	A. Huddleston, C N A			J. Savell, LPN	12-2016
	B. Byington, LPN		12-2016	E. Jarvis, MA		12-2016	B. Smith, C N A	12-2016
	G. Capshaw, RN		12-2016	D. Jensen, LPN		12-2016	L. Tice, C N A	12-2016
	~~T. Case, LPN~~		12-2016	~~M. Jimenez, RN~~		12-2016	~~T. Vaudrin MA~~	12-2016
	P. J. Cash, RN		12-2016	K. Larsen, LPN		12-2016	C. Wilson, LPN	12-2016
	M. Chavez, MA		12-2016	T. Lee, RN		12-2016	D. Wilson, C N A	12-2016
	~~P. Cleveland, MA~~		12-2016	~~C. Luster, CMS~~		12-2016	~~N. Wise, RN~~	12-2016
	A. Cooper, MA		12-2016	S. Mallett, LPN		12-2016	E. Zhou, LPN	
	C. Curtis, LPN		12-2016	C. Marria, LPN		12-2016		12-2016
			12-2016	~~N. Give, LPN~~		12-2016		12-2016

Date/Time		
11.24.16	J. Buckles, RN	QB J. Buckles, RN M. Hampton, LPN NOTE Chronic Care Referral sent SMH
12/6/16	pm	absent BB
12/12/16	PM	Absent CA
12-14-16	AM	Absent for pill pass 20

ER 2162

ER 2163

MEDICATION ADMINISTRATION RECORD

Facility: 6340 Month: December 2016

Init.	Drug - Dose - Mode - Interval	HR	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
	Medroxyprogesterone 10mg po QD Approved x90 days Prescriber Bushnell 12.22.16 Order Date 12.19.16 Start Date 12.2 Stop Date 3.2017	A	
	Estradial 3mg Po BID Sublingually x90 days Prescriber Bushnell Order Date 12.19.16 Start Date 12 Stop Date		Not approved
	Spironolactone 150mg Po BID x1 year Prescriber Bushnell Order Date 12.19.16 Start Date 12.2016 Stop Date 12.19.17	A 0	
	Estrace 3mg Po BID Crush x90 days Prescriber Povar Order Date 12.20.16 Start Date 12.2016 Stop Date 3.28.16	A D	
	Prescriber Order Date Start Date Stop Date		
	Prescriber Order Date Start Date Stop Date		

[redacted]

Diagnosis:

Allergies:

94691 DOB/Inmate #: 6340 Location: Edmo, Mason Name: 3/3

#3150 REV 4/10

Medication Administration Record

Documentation Codes	Staff Signature	Initials / Signature	Date	Staff Signature	Initials / Signature	Date	Staff Signature	Initials / Signature	Date
	K. Barney, LPN	KB [illegible]	12-2016	J. Drake, LPN	JD J. Drake	12-2016	T. Mccall, LPN	[illegible]	12-2016
	~~L. Berryman, CMS~~	[illegible]	12-2016	L. Eagle, RN	LE L Eagle	12-2016	E. Mitchell, RN	E Mitchell	12-2016
D/C - Discontinued Order	M. Beck, RN	MB M Beck	12-2016	V. Ferro, LPN	VF [illegible]	12-2016	S. Patterson, LPN	[illegible]	12-2016
R - Refused	A. Benton, RN, DON	AB [illegible]	12-2016	S. Harrod, MA	SH [illegible]	12-2016	S. Perus, LPN	S. Perus	12-2016
	~~A. Beshears, RN~~	AB [illegible]	12-2016	~~S. Hawk, LPN~~	SH S. Hawk	12-2016	~~H. Pierce, LPN~~		12-2016
A - Absent	G. Blackburn, LPN	GB [illegible]	12-2016	L. Hill, PhT	LH [illegible]	12-2016	A. Pope, C N A	AP [illegible]	12-2016
	C. Brenenstahl, dialysis tech	[illegible]	12-2016	~~N. Hoffman, LPN~~		12-2016	D. Rainier, LPN	D Rainier	12-2016
O - Other	G. Brewer, RN, DON	[illegible]	12-2016	[redacted] LPN		12-2016	B. Reece, LPN	[illegible]	12-2016
	L. Brown, LPN	LB [illegible]	12-2016	C. Hoopes, CMS	[illegible]	12-2016	G. Rodriguez, LPN	[illegible]	12-2016
	J. Bryant, MA	JB [illegible]	12-2016	A. Huddleston, C N A	[illegible]	12-2015	J. Savell, LPN	[illegible]	12-2016
	B. Byington, LPN	BB [illegible]	12-2016	E. Jarvis, MA	EJ [illegible]	12-2016	B. Smith, C N A	[illegible]	12-2016
	G. Capshaw, RN	[illegible]	12-2016	D. Jensen, LPN	DJ [illegible]	12-2016	L. Tice, C N A	LT [illegible]	12-2016
	T. Case, LPN	TC [illegible]	12-2016	~~M. Jimenez, RN~~		12-2016	~~T. Vaudrin MA~~	[illegible]	12-2016
	P. J. Cash, RN	PJC P Cash RN	12-2016	K. Larsen, LPN	KL K Larsen	12-2016	C. Wilson, LPN	CW C Wilson	12-2016
	M. Chavez, MA	M [illegible]	12-2016	T. Lee, RN	[illegible]	12-2016	D. Wilson, C N A	DW [illegible]	12-2016
	~~P. Cleveland, MA~~	PC P Cleveland	12-2016	~~C. Luster, CMS~~	CL [illegible]	12-2016	~~N. Wise, RN~~	NW [illegible]	12-2016
	A. Cooper, MA	AC [illegible]	12-2016	S. Mallett, LPN	SM S Mallett	12-2016	E. Zhou, LPN	EZ [illegible]	12-2016
	C. Curtis, LPN	CC C Curtis	12-2016	C. Marria, LPN	CM [illegible]	12-2016			12-2016
			12-2016	N. Giove, LPN	NG [illegible]	12-2016			12-2016

Date/Time	
	J. Buckles, RN — JB J Buckles RN — M. Hampson, LPN NO [illegible]
12-30 Pm	Absent [illegible]
[illegible]-31-16 PM	PA OSS [illegible]

Pg.302
Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID

Month: December 2016

Drug - Dose - Mode - Interval	HR	Notes
ASPIRIN EC 81 MG TBEC ~ECOTRIN~ TAKE 1 TAB BY MOUTH EVERY DAY FOR 12 MONTHS >> DO NOT CRUSH << Prescriber POULSON,WILLIAM NP Rx#34454692 Order Date 12/23/15 Start Date 12·24·15 Stop Date 12/17/16	A	Stop
CALCIUM CARB 1250MG/VIT D 1250 MG TABS ~OSCAL-D 500~ TAKE 1 TAB BY MOUTH AT BEDTIME FOR 12 MONTHS Prescriber POULSON,WILLIAM NP Rx#34454696 Order Date 12/23/15 Start Date 12·24·15 Stop Date 12/17/16	P	NEW ORDER; Stop
ESTRADIOL 2 MG TABS ~ESTRACE~ TAKE 3 TABS (6MG) BY MOUTH EVERY DAY FOR 90 DAYS **APPROVED** Prescriber AGLER,DAVID,MD Rx#36322303 Order Date 09/26/16 Start Date 9·26·16 Stop Date 12/25/16	A	12·8 start new order; Stop
FINASTERIDE 5 MG TABS ~PROSCAR~ TAKE 1 TAB BY MOUTH EVERY DAY FOR 90 DAYS >>WOMEN OF CHILD BEARING AGE SHOULD NOT HANDLE THIS DRUG<< Prescriber AGLER,DAVID,MD Rx#36322283 Order Date 09/08/16 Start Date 9·8·16 Stop Date 12/08/16	A	NEW ORDER; Stop
SPIRONOLACTONE 100 MG TABS ~ALDACTONE~ TAKE 1 TAB (WITH 25MG) BY MOUTH TWICE DAILY FOR 12 MONTHS >> MAY CAUSE DIZZINESS << Prescriber AGLER,DAVID,MD Rx#36201111 Order Date 09/08/16 Start Date 9·9·16 Stop Date 09/03/17	A / P	
Oscal-D 500 PO QHS x12months Prescriber Dellwo Order Date 11·29·16 Start Date 11·30·16 Stop Date 11·30·17	P	30

[redacted]

94691 6340- MAIN(00) EDMO, MASON 1/3

Diagnosis: No Known Drug Allergy

Allergies: DOB/Inmate #: Location: Name:

PharmaCorr

93130 REV. 4/10

Medication Administration Record

Documentation Codes	Staff Signature	Date	Initials	Staff Signature	Date	Initials
K. Barney, LPN		12-2016	J. Drake, LPN		12-2016	T. Mccall, LPN
~~L. Barryman, CMS~~		12-2016	L. Eagle, RN		12-2016	E. Mitchell, RN
D/C - Discontinued Order M. Beck, RN		12-2016	V. Ferro, LPN		12-2016	S. Patterson, LPN
R - Refused A. Benton, RN, DON		12-2016	S. Harrod, MA		12-2016	S. Perus, LPN
A. Beshears, RN		12-2016	S. Hawk, LPN		12-2016	~~H. Pierce, LPN~~
A - Absent G. Blackburn, LPN		12-2016	L. Hill, PhT		12-2016	A. Pope, C N A
C. Brenenstahl, dialysis tech		12-2016	~~N. Hoffman, LPN~~		12-2016	D. Rainier, LPN
O - Other G. Brewer, RN, DON		12-2016	~~N. Homme, LPN~~		12-2016	B. Reece, LPN
L. Brown, LPN		12-2016	C. Hoopes, CMS		12-2016	G. Rodriguez, LPN
J. Bryant, MA		12-2016	A. Huddleston, C N A		12-2016	J. Savell, LPN
B. Byington, LPN		12-2016	E. Jarvis, MA		12-2016	B. Smith, C N A
G. Capshaw, RN		12-2016	D. Jensen, LPN		12-2016	L. Tice, C N A
T. Case, LPN		12-2016	M. Jimenez, RN		12-2016	T. Vaudrin MA
P. J. Cash, RN		12-2016	K. Larsen, LPN		12-2016	C. Wilson, LPN
M. Chavez, MA		12-2016	T. Lee, RN		12-2016	D. Wilson, C N A
P. Cleveland, MA		12-2016	C. Luster, CMS		12-2016	N. Wise, RN
A. Cooper, MA		12-2016	S. Mallett, LPN		12-2016	E. Zhou, LPN
C. Curtis, LPN		12-2016	C. Marria, LPN		12-2016	
		12-2016	N. Gioia, LPN		12-2016	

Date/Time			
	J. Buckley, RN	JB J. Buckley, RN	M. Harper, LPN NOT
12/16/16 pm	absent	BB	
12/14/14 pm	Absent	CA	
12-14-16	Am	Absent for pill pass	

ER 2166

Medication Administration Record

Documentation Codes	Staff Signature	Date	Staff Signature	Date	Staff Signature	Date
	K. Barney, LPN	12-2016	J. Drake, LPN	12-2016	T. Mccall, LPN	12-2016
D/C - Discontinued Order	L. Berryman, CMS	12-2016	L. Eagle, RN	12-2016	E. Mitchell, RN	
	M. Beck, RN	12-2016	V. Ferro, LPN	12-2016	S. Patterson, LPN	12-2016
R - Refused	A. Benton, RN, DON	12-2016	S. Harrod, MA	12-2016	S. Perus, LPN	12-2016
	A. Beshears, RN	12-2016	S. Hawk, LPN	12-2016	H. Pierce, LPN	12-2016
A - Absent	G. Blackburn, LPN	12-2016	L. Hill, PhT	12-2016	A. Pope, C N A	12-2016
O - Other	C. Brenenstahl, dialysis tech	12-2016	N. Hoffman, LPN	12-2016	D. Rainier, LPN	12-2016
	G. Brewer, RN, DON	12-2016	N. Homme, LPN	12-2016	B. Reece, LPN	12-2016
	L. Brown, LPN	12-2016	C. Hoopes, CMS	12-2016	G. Rodriguez, LPN	12-2016
	J. Bryant, MA	12-2016	A. Huddleston, C N A	12-2016	J. Savell, LPN	12-2016
	B. Byington, LPN	12-2016	E. Jarvis, MA	12-2016	B. Smith, C N A	12-2016
	G. Capshaw, RN	12-2016	D. Jensen, LPN	12-2016	L. Tice, C N A	12-2016
	I. Case, LPN	12-2013	M. Jimenez, RN	12-2016	T. Vaudrin MA	12-2016
	P. J. Cash, RN	12-2015	K. Larsen, LPN	12-2016	C. Wilson, LPN	12-2016
	M. Chavez, MA	12-2015	T. Lee, RN	12-2016	D. Wilson, C N A	12-2016
	P. Cleveland, MA	12-2016	C. Luster, CMS	12-2016	N. Wise, RN	12-2016
	A. Cooper, MA	12-2016	S. Mallett, LPN	12-2016	E. Zhou, LPN	
	C. Curtis, LPN	12-2016	C. Marria, LPN	12-2016		12-2016
	James Hecht, LPN	12-2016	N Giove, LPN	12-2016		12-2016

Date/Time	NOTES
J. Buckles, RN	JB J Buckles RN M. Hampson, LPN
1·25	Pm Absent - [illegible]

Medication Administration Record

Documentation Codes	Staff Signature	Initials / Signature	Date	Staff Signature	Initials / Signature	Date	Staff Signature	Initials / Signature	Date
	~~K. Barney, LPN~~		12-2016	J. Drake, LPN		12-2016	T. Mccall, LPN		12-2016
D/C - Discontinued Order	~~L. Barryman, CMS~~		12-2016	L. Eagle, RN		12-2016	E. Mitchell, RN		12-2016
	M. Beck, RN		12-2016	~~V. Ferro, LPN~~		12-2016	~~S. Patterson, LPN~~		12-2016
R - Refused	A. Benton, RN, DON		12-2016	S. Harrod, MA		12-2016	S. Perus, LPN		12-2016
	A. Beshears, RN		12-2016	S. Hawk, LPN		12-2016	~~H. Pierce, LPN~~		12-2016
A - Absent	G. Blackburn, LPN		12-2016	L. Hill, PhT		12-2016	A. Pope, C N A		12-2016
O - Other	C. Brenenstahl, dialysis tech		12-2016	~~N. Hoffman, LPN~~		12-2016	D. Rainier, LPN		12-2016
	G. Brewer, ~~RN, DON~~		12-2016	~~N. Homme, LPN~~		12-2016	~~B. Reece, LPN~~		12-2016
	L. Brown, LPN		12-2016	C. Hoopes, CMS		12-2016	G. Rodriguez, LPN		12-2016
	J. Bryant, MA		12-2016	A. Huddleston, C N A			~~J. Savell, LPN~~		12-2016
	~~B. Byington, LPN~~		12-2016	~~E. Jarvis, MA~~		12-2016	B. Smith, C N A		12-2016
	G. Capshaw, RN		12-2016	D. Jensen, LPN		12-2016	L. Tice, C N A		12-2016
	T. Case, LPN	Case LPN	12-2016	~~M. Jimenez, RN~~		12-2016	~~T. Vaudrin MA~~		12-2016
	P. J. Cash, RN	PCash RN	12-2016	~~K. Larsen, LPN~~		12-2016	C. Wilson, LPN		12-2016
	M. Chavez, MA		12-2016	T. Lee, RN		12-2016	D. Wilson, C N A		12-2016
	P. Cleveland, ~~MA~~	PCleveland	12-2016	~~C. Luster, CMS~~		12-2016	~~N. Wise, RN~~		12-2016
	A. Cooper, MA		12-2016	S. Mallett, LPN	Smallett	12-2016	E. Zhou, LPN		12-2016
	C. Curtis, LPN		12-2016	C. Marria, LPN		12-2016			12-2016
			12-2016	Giove, LPN		-20-			12-2016

Date/Time	J. Buc[redacted]s, RN JB JBuckley RN M. Hampen, LPN NOTES
1/6/17 N - Absent	
1/7/17 N - Absent	
27 pm	Refused Email - ES
1/2/17 pm	refused, numbers
1/13/17 pm	refused numbers

MEDICATION ADMINISTRATION RECORD

Facility: ISCI 6340 **Month:** Jan 2017

Init.	Drug - Dose - Mode - Interval	HR	Days 1–31
	Augmentin 500mg po TID x 10 days Prescriber Dellwo Order Date 1/1/17 Start Date 1/1/17 Stop Date 1/11/17	A N P	[illegible initials] D/C p̄ am dose 01/11 am; stop
	T4's ⅱ pox ī NOW Prescriber Dellwo Order Date 1/1/17 Start Date 1/1/17 Stop Date 1/1/17	NOW	1/30 [illegible]
	T4 ī po TID x 5 days Prescriber Dellwo Order Date 1/1/17 Start Date 1/1/17 Stop Date 1/6/17	A N P	[illegible initials] stop
	Effexor XR 300mg po qAm x120d Prescriber Stoddart Order Date 1/3/17 Start Date 1/4/17 Stop Date 5/3/17	A	[illegible initials] NEW ORDER
	Effexor XR 300mg PO Q AM x120 days Prescriber Seys Order Date 1·26·17 Start Date 1·27·17 Stop Date 5·27·17	A	→ [illegible initials] 60
B	Remeron 15 mg PO Q HS x120 days crush Prescriber Seys Order Date 1·26·17 Start Date 1·27·17 Stop Date 5·27·17	P	→ 30 [illegible initials]

Diagnosis:

Allergies: NKDA

DOB/Inmate #: # 94691 [redacted]

Location: ISCI 6340

Name: Edmo, Mason

#3150 REV 4/10

MEDICATION ADMINISTRATION RECORD

Facility: ISCI **Month:** January 2017

Drug - Dose - Mode - Interval	HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Oscal-D 500 1 po QHS x 12 months Prescriber Dellwo Order Date 11-29-16 Start Date 11-30-16 Stop Date 11-30-17	PM																															
Venlafaxine HCL XR 150mg -Effexor XR- Take 2 caps (300mg) QAM for 90 days Prescriber Seys * DO NOT CRUSH * Order Date 10-20-16 Start Date 10-21-16 Stop Date 01-18-17	AM																															
Proscar 5mg po daily x 90 days NON FORM *approved Prescriber Dellwo Order Date 11-29-16 Start Date 12-03-16 Stop Date 03-03-17	AM																															
Medroxyprogesterone 10mg po daily approved x 90 days Prescriber Bushnell Order Date 12-19-16 Start Date 12-22-16 Stop Date 03-22-17	AM																															
Spironolactone 50mg po BID x 1 year Prescriber Bushnell Order Date 12-19-16 Start Date 12-20-16 Stop Date 12-19-17	AM																															
Estrace 3mg po BID x 90 days CRUSH Prescriber Povar Order Date 12-20-16 Start Date 12-23-16 Stop Date 03-23-16	AM																															
	PM																															

94691

Diagnosis:

Allergies: NKDA

DOB/Inmate #: Location: Name: Edmo, Mason

Pg:292
Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID **Month:** February 2017

Init.	Drug - Dose - Mode - Interval	HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	VENLAFAXINE HCL XR 150 MG CP24 ~EFFEXOR XR~ TAKE 2 CAPS (300MG) BY MOUTH EACH MORNING FOR 120 DAYS > DO NOT CRUSH; MAY CAUSE DROWSINESS << Prescriber STODDART,JEREMY,MD Rx#37000544 Order Date 01/03/17 Start Date 1/4 Stop Date 05/03/17	A																															
B	Effexor XR 300mg PO Q AM x 120 days Prescriber Seys Order Date 1-26-17 Start Date 1-27-17 Stop Date 5-27-17	A																															
B	Remeron 15mg PO Q HS x 120 days CRUSH Prescriber Seys Order Date 1-26-17 Start Date 1-27-17 Stop Date 5-27-17	P																					D/C for Stoddart										
M	Estrace 3mg SL BID x90 days do not crush Prescriber Valley Order Date 2-14-17 Start Date 2-15-17 Stop Date 5-14-17	M																															
		P																															
	Proscar 5mg PO Q day x 90 days Prescriber Dice Order Date 2-16-17 Start Date 2-17-17 Stop Date 5-16-17	A																															
	Prescriber Order Date Start Date Stop Date																																

Diagnosis:

Allergies: No Known Drug Allergy

[redacted] 94691 DOB/Inmate #:

6340- MAIN(00) Location: B42

EDMO, MASON Name:

2/2

#3150 REV 4/10

PharmaCorr

ER 2171

Medication Administration Record

Documentation Codes		Date	Initials	Staff Signature		Date	Initials
	K. Barney, LPN	2-2017		C. Curtis, LPN		2-2017	
	~~J. Barryman, CMS~~	2-2017		J. Drake, LPN		2-2017	
D/C - Discontinued Order	~~Bauer, LPN~~	2-2017		L. Eagle, RN		2-2017	
R - Refused	M. Beck, RN	2-2017		V. Ferro, LPN		2-2017	
	A. Benton, RN, DON	2-2017		N. Giove, LPN		2-2017	
A - Absent	A. Beshears, RN	2-2017		M. Harper, LPN		2-2017	
	G. Blackburn, LPN	2-2017		S. Harrod, MA		2-2017	
O - Other	~~C. Brenenstahl, dialysis tech~~	2-2017		S. Hawk, LPN		2-2017	
	G. Brewer, RN, DON	2-2017		L. Hill, PhT		2-2017	
	L. Brown, LPN	2-2017		N. Hoffman, LPN		2-2017	
	J. Bryant, MA	2-2017		C. Hoopes, CMS		2-2017	
	~~J. Buckles, RN~~	2-2017		A. Huddleston, C N A		2-2017	
	G. Capshaw, RN	2-2017		E. Jarvis, MA		2-2017	
	T. Case, LPN	2-2017		D. Jensen, LPN		2-2017	
	P. J. Cash, RN	2-2017		M. Jimenez, RN		2-2017	
	M. Chavez, MA	2-2017		K. Larsen, LPN		2-2017	
	P. Cleveland, MA	2-2017		T. Lee, RN		2-2017	
	A. Cooper, MA	2-2017		C. Luster, CMS		2-2017	
	J Hecht LPN	2-2017		S. Mallett, LPN		2-2017	
	C. Marria, LPN	2-2017					
	T. Mccall, LPN	2-2017					
	E. Mitchell, RN	2-2017					
	S. Patterson, LPN	2-2017					
	S. Perus, LPN	2-2017					
	H. Pierce, LPN	2-2017					
	~~A. Pope, C N A~~	2-2017					
	D. Rainier, LPN	2-2017					
	B. Reece, LPN	2-2017					
	G. Rodriguez, LPN	2-2017					
	J. Savell, LPN	2-2017					
	J. Shaffer, LPN	2-2017					
	~~B. Smith, C N A~~	2-2017					
	L. Tice, C N A	2-2017					
	C. Wilson, LPN	2-2017					
	D. Wilson, C N A	2-2017					
	N. Wise, RN	2-2017					
	E. Zhou, LPN	2-2017					
	~~Kristine Bailey, LPN~~	2-2017					

Date/Time	NOTES
2.18.17 pm	pt absent - K Hay

ER 2172

Pg:291
Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID **Month:** February 2017

Drug - Dose - Mode - Interval	HR
CALCIUM CARB 1250MG/VIT D 1250 MG TABS ~OSCAL-D 500~ TAKE 1 TAB BY MOUTH AT BEDTIME FOR 12 MONTHS Prescriber DELLWO,DANIEL PA Rx#36770254 Order Date 11/30/16 Start Date 11/30 Stop Date 11/25/17	P
ESTRADIOL 1 MG TABS ~ESTRACE~ TAKE 3 TABS BY MOUTH TWICE DAILY **CRUSH ALL DOSES** FOR 90 DAYS **APPROVED** Prescriber BUSHNELL,ANTHONY,PA Rx#36925697 Order Date 12/21/16 Start Date 12/23 Stop Date 03/21/17	A P
FINASTERIDE 5 MG TABS ~PROSCAR~ TAKE 1 TAB BY MOUTH EVERY DAY FOR 90 DAYS **APPROVED** >>WOMEN OF CHILD BEARING AGE SHOULD NOT HANDLE THIS DRUG<< Prescriber DELLWO,DANIEL PA Rx#36791429 Order Date 12/01/16 Start Date 12/3 Stop Date 03/01/17	A
MEDROXYPROGESTERONE 10 MG TABS ~PROVERA~ TAKE 1 TAB BY MOUTH EVERY DAY FOR 90 DAYS **APPROVED** Prescriber BUSHNELL,ANTHONY,PA Rx#36912292 Order Date 12/20/16 Start Date 12/22 Stop Date 03/20/17	A
SPIRONOLACTONE 100 MG TABS ~ALDACTONE~ TAKE 1 TAB (WITH 50MG) BY MOUTH TWICE DAILY FOR 12 MONTHS >> MAY CAUSE DIZZINESS << Prescriber BUSHNELL,ANTHONY,PA Rx#36956004 Order Date 12/19/16 Start Date 12/20 Stop Date 12/14/17	A P
SPIRONOLACTONE 50 MG TABS ~ALDACTONE~ TAKE 1 TAB (WITH 100MG) BY MOUTH TWICE DAILY FOR 12 MONTHS >> MAY CAUSE DIZZINESS << Prescriber BUSHNELL,ANTHONY,PA Rx#36955989 Order Date 12/19/16 Start Date 12/20 Stop Date 12/14/17	A P

NEW ORDER

New order

Diagnosis:

[redacted]
94691 6340- MAIN(00) **EDMO, MASON** 1/2

No Known Drug Allergy
Allergies: DOB/Inmate #: Location: B42 Name:

#3150 REV 4/10 PharmaCorr

Medication Administration Record

Documentation Codes	Staff Signature	Date	Staff Signature	Date	Staff Signature	Date
	K. Barney, LPN	2-2017	C. Curtis, LPN		C. Marria, LPN	2-2017
	~~J. Berryman, CMS~~	2-2017	J. Drake, LPN	2-2017	T. Mccall, LPN	2-2017
D/C - Discontinued Order	[illegible]auer, LPN	2-2017	~~L. Eagle, RN~~	17	E. Mitchell, RN	2-2017
R - Refused	M. Beck, RN	2-2017	V. Ferro, LPN	2-2017	S. Patterson, LPN	2-2017
	A. Benton, RN, DON	2-2017	~~N. Giove, LPN~~	2-2017	~~S. Perus, LPN~~	2-2017
A - Absent	A. Beshears, RN	2-2017	M. Harper, LPN	2-2017	H. Pierce, LPN	2-2017
O - Other	G. Blackburn, LPN	2-2017	S. Harrod, MA	2-2017	~~A. Pope, C N A~~	2-2017
	~~C. Brenenstahl, dialysis tech~~	2-2017	S. Hawk, LPN	2-2017	D. Rainier, LPN	2-2017
	G. Brewer, RN, DON	2-2017	L. Hill, PhT	2-2017	B. Reece, LPN	2-2017
	L. Brown, LPN	2-2017	N. Hoffman, LPN	2-2017	G. Rodriguez, LPN	2-2017
	J. Bryant, MA	2-2017	C. Hoopes, CMS	2-2017	J. Savell, LPN	2-2017
	~~J. Buckles, RN~~	2-2017	A. Huddleston, C N A		J. Shaffer, LPN	2-2017
	G. Capshaw, RN	2-2017	~~E. Jarvis, MA~~	2-2017	~~B. Smith, C N A~~	2-2017
	T. Case, LPN	2-2017	D. Jensen, LPN	2-2017	L. Tice, C N A	2-2017
	P. J. Cash, RN	2-2017	M. Jimenez, RN	2-2017	C. Wilson, LPN	2-2017
	~~M. Chavez, MA~~	2-2017	~~K. Larsen, LPN~~		~~D. Wilson, C N A~~	2-2017
	P. Cleveland, MA	2-2017	T. Lee, RN		N. Wise, RN	2-2017
	A. Cooper, MA	2-2017	C. Luster, CMS	2-2017	E. Zhou, LPN	2-2017
	J Heckt LPN	2-2017	~~S. Mallett, LPN~~	2-2017	~~Kristina Bauer, LPN~~	2-2017

Date/Time	NOTES
2-1-17 P	Refused Remeron
2/2/17 pm	refused Remeron
2-3-17 pm	Refused Remeron provider notified
2-4-17 am	refused remeron
2-5 pm	Refused Remeron
2-7 pm	Refused Remeron
2-8 pm	Refused Remeron
2-9 pm	Refused Remeron prov not.
2-11 am	refused [illegible]
2-12-P	Refused Remeron
2-13-P	Refused Remeron Provider Notified
2-18-17	pt absent eve

65410-

CORRECTIONAL MEDICAL SERVICES, INC.
PHARMACORR, LLC
OKLAHOMA CITY FAX # 1 888-280-7776
INDIANAPOLIS FAX # 1-800-269-3066
NON-FORMULARY DRUG TRACKING FORM

Date: 8/30/12

Institution: Idaho State Correctional Institution

Inmate Name: Edmo, Mason

Inmate ID#: 94691 Unit:

Diagnosis: GID DOB: [redacted]

Past Medical History:

Allergies: NKA

1) Drug: Estrace 0.5mg Refill Y/N Sig 1x d x 90 days

2) Drug: Refill Y/N Sig x Days

Medications in use:

Note: Maximum of 90 day stop date on all non-formulary drugs.

If profile only check ☐ Yes (Medication will not be sent)

Why must this drug be used instead of one included on the formulary?
9/11/12 Gender identity disorder - pt wants female hormones to decrease hair growth & ↑ breast growth.

What formulary drugs have been tried? What was outcome?

Cathy Whinnery, M.D.

FAXED 9/5/12 Ø response

FAXED 9/20/12

Ordering Physician: PRINT NAME
Ordering Physician Signature Date: 8/30/12
DEA #: (required for controlled substances)

If it is imperative the medication be started ASAP, call the pharmacist directly, in advance of sending this form, 1-888-[illegible]. Please note: Non-formulary drugs may not be kept as stock medications. Therefore, if a medication must be initiated immediately, please obtain medications from the back-up pharmacy until the medication is received from PharmaCorr, LLC.

Observations/Comments for Provider Feedback (e.g. does the Reviewer concur with the prescription, request additional information, or suggest consideration of alternates or other options?)

☐ Faxed to PharmaCorr, LLC
☐ Faxed to site for Physician review

Reviewer's Signature ______
☐ Non-formulary order forwarded to Pharma...

Ordering Physician Signature: ______
Telephone: ( ) ______

Alternative Treatment
615-320-8631 x2719
By Dr. Glen Babich at 11:52 pm, Sep 19, 2012

...ative Treatment
...20-8631 x2719
Dr. Glen Babich at 2:50 pm, Sep 05, 2012

Approved for Pharmacorr
615-320-8631 x2719
By Dr. Glen Babich at 1:55 pm, Sep 21, 2012

THIS FORM IS FOR TRACKING, INFORMATIONAL, AND FEEDBACK PUR... BE CONSTRUED, AS AN APPROVAL/DENIAL FORM. THE TREATING ... UPON THE INDIVIDUAL PATIENT'S MEDICAL CONDITION AND HIST... EDUCATIONAL EXPERIENCE, AND PROFESSIONAL CONSULTATIONS, ...

FAXED 9/12/12

Additional information needed: is there documented psychiatric Dx of GID?

Please provider confirmation of GID. Provide copy of psychiatrist's assessment confirming dx

FAXED 9/12/12

Thank you for additional information

CC# 6340-

CORRECTIONAL MEDICAL SERVICES, INC.
PHARMACORR, LLC
OKLAHOMA CITY FAX # 1-888-200-7774
INDIANAPOLIS FAX # 1-800-259-3066
NON-FORMULARY DRUG TRACKING FORM

Date: 3/26/13 Institution: Idaho State Correctional Institution Unit:

Inmate Name: Edmo, Adrian Inmate ID#: 94691 DOB: [redacted]

Diagnosis: GID Allergies: NKDA

Past Medical History:

1) Drug: Estradiol 1mg Refill Y/N Sig 1 po daily x 90 days

2) Drug: Refill Y/N Sig x Days

Medications in use:

Note: Maximum of 90 day stop date on all non-formulary drugs.

If profile only check ☐ Yes (Medication will not be sent)

Why must this drug be used instead of one included on the formulary?

What formulary drugs have been tried? What was outcome?

Ordering Physician: PRINT NAME C. Whinnery, M.D. Date: 3/26/13

Ordering Physician Signature

DEA #: (required for controlled substances)

If it is Imperative the medication be started ASAP, call the pharmacist directly, in advance of sending this form. 1-888-200-9060
Please note: Non-formulary drugs may not be kept as stock medications. Therefore, if a medication must be initiated immediately, please obtain medications from the back-up pharmacy until the medication is received from PharmaCorr, LLC.

Observations/Comments for Provider Feedback (e.g. does the Reviewer concur with the prescription, request additional information, or suggest consideration of alternates or other options?)

Approved for Pharmacorr:
208-322-3555 x1302

☐ Faxed to PharmaCorr, LLC
☐ Faxed to site for Physician review

Reviewer's Signature _____ D
☐ Non-formulary order forwarded to PharmaCorr ☐ No

Ordering Physician Signature: _____ Date: _____

Telephone: ( ) _____

THIS FORM IS FOR TRACKING, INFORMATIONAL, AND FEEDBACK PURPOSES ONLY. IT IS NEITHER INTENDED, NOR SHOULD IT BE CONSTRUED, AS AN APPROVAL/DENIAL FORM. THE TREATING PHYSICIAN MUST MAKE ALL MEDICAL DECISIONS BASED UPON THE INDIVIDUAL PATIENT'S MEDICAL CONDITION AND HISTORY, AND THE PHYSICIAN'S PROFESSIONAL JUDGMENT, EDUCATIONAL EXPERIENCE, AND PROFESSIONAL CONSULTATIONS, IF APPLICABLE.

02/07

4

CC# 6340-[ ]

CORRECTIONAL MEDICAL SERVICES, INC.
PHARMACORR, LLC
OKLAHOMA CITY FAX # 1-888-200-7774
INDIANAPOLIS FAX # 1-800-259-3066
NON-FORMULARY DRUG TRACKING FORM

Date: 5/29/13 Institution: Idaho State Correctional Institution Unit:

Inmate Name: Edmo, Mason Inmate ID#: 99691 DOB: [redacted]

Diagnosis: GID Allergies: NKDA
Past Medical History:

✓ 1) Drug: Estradiol 2mg Tab Refill Y/N Sig 2mg po daily x 90 days

✓ 2) Drug: Finasteride 5mg Refill Y/N Sig 1 po daily x 90 Days

Medications in use:

Note: Maximum of 90 day stop date on all non-formulary drugs.

If profile only check ☐ Yes (Medication will not be sent)

Why must this drug be used instead of one included on the formulary?

Pt failure with spironolactone

What formulary drugs have been tried? What was outcome?

Ordering Physician: PRINT NAME C. Whinnery Date 5/29/13
Ordering Physician Signature
DEA #: (required for controlled substances)

If it is imperative the medication be started ASAP, call the pharmacist directly, in advance of sending this form. 1-888-200-9060
Please note: Non-formulary drugs may not be kept as stock medications. Therefore, if a medication must be initiated immediately, please obtain medications from the back-up pharmacy until the medication is received from PharmaCorr, LLC.

Observations/Comments for Provider Feedback (e.g. does the Reviewer concur with the prescription, request additional information, or suggest consideration of alternates or other options?)

Approved for Pharmacorr:
208-322-3555 x1302

☐ Faxed to PharmaCorr, LLC
☐ Faxed to site for Physician review

Reviewer's Signature Date
☐ Non-formulary order forwarded to PharmaCorr ☐ Non-formulary ord

Ordering Physician Signature: Date:
Telephone: ( )

THIS FORM IS FOR TRACKING, INFORMATIONAL, AND FEEDBACK PURPOSES ONLY. IT IS NEITHER INTENDED, NOR SHOULD IT BE CONSTRUED, AS AN APPROVAL/DENIAL FORM. THE TREATING PHYSICIAN MUST MAKE ALL MEDICAL DECISIONS BASED UPON THE INDIVIDUAL PATIENT'S MEDICAL CONDITION AND HISTORY, AND THE PHYSICIAN'S PROFESSIONAL JUDGMENT, EDUCATIONAL EXPERIENCE, AND PROFESSIONAL CONSULTATIONS, IF APPLICABLE. 02/07

CC# 6340-[ ]

CORRECTIONAL MEDICAL SERVICES, INC.
PHARMACORR, LLC
OKLAHOMA CITY FAX # 1-888-200-7774
INDIANAPOLIS FAX # 1-800-259-3066
NON-FORMULARY DRUG TRACKING FORM

Date: 7/1/13 Institution: Idaho State Correctional Institution Unit:

Inmate Name: Edna, Masa Inmate ID#: 94691 DOB: [redacted]

Diagnosis: GID Allergies: NKDA
Past Medical History :

1) Drug: Estradiol 2mg Refill Y/N Sig: 1 po daily x 90 days

2) Drug: Proscar 5mg Refill Y/N Sig: 1 po daily x 90 Days

Medications in use:

Note: Maximum of 90 day stop date on all non-formulary drugs.

If profile only check ☐ Yes (Medication will not be sent)

Why must this drug be used instead of one included on the formulary? These orders to start 8/29/13

What formulary drugs have been tried? What was outcome?

Ordering Physician: PRINT NAME C. Whinnery, M.D. Date: 7/1/13
Ordering Physician Signature
DEA #: (required for controlled substances)

If it is imperative the medication be started ASAP, call the pharmacist directly, in advance of sending this form. 1-888-200-9060
Please note: Non-formulary drugs may not be kept as stock medications. Therefore, if a medication must be initiated immediately, please obtain medications from the back-up pharmacy until the medication is received from PharmaCorr, LLC.

Observations/Comments for Provider Feedback (e.g. does the Reviewer concur with the prescription, request additional information, or suggest consideration of alternates or other options?)

☐ Faxed to PharmaCorr, LLC
☐ Faxed to site for Physician review

Reviewer's Signature [redacted] Date 7/11/13
☐ Non-formulary order forwarded to PharmaCorr ☐ Non-formulary order withdrawn

Ordering Physician Signature: _____ Date: _____
Telephone: ( ) _____

THIS FORM IS FOR TRACKING, INFORMATIONAL, AND FEEDBACK PURPOSES ONLY. IT IS NEITHER INTENDED, NOR SHOULD IT BE CONSTRUED, AS AN APPROVAL/DENIAL FORM. THE TREATING PHYSICIAN MUST MAKE ALL MEDICAL DECISIONS BASED UPON THE INDIVIDUAL PATIENT'S MEDICAL CONDITION AND HISTORY, AND THE PHYSICIAN'S PROFESSIONAL JUDGMENT, EDUCATIONAL EXPERIENCE, AND PROFESSIONAL CONSULTATIONS, IF APPLICABLE.

02/07

CC# 6344-[ ]

CORIZON
PHARMACORR, LLC
OKLAHOMA CITY FAX # 1-888-200-7774
INDIANAPOLIS FAX # 1-800-259-3066
NON-FORMULARY DRUG TRACKING FORM

Date: 8/13/13 Institution: ICI-O Unit:

Inmate Name: Edno, Mason Inmate ID#: 94691 DOB: [redacted]

Diagnosis: GTD Allergies:
Past Medical History:
GTD

1) Drug: Prozac Refill Y/N Sig 5mg PO daily #90 days

2) Drug: Estradiol 2mg PO daily Refill Y/N Sig 2mg PO daily #90 Days

Medications in use:

Note: Maximum of 90 day stop date on all non-formulary drugs.

If profile only check ☐ Yes (Medication will not be sent)

Why must this drug be used instead of one included on the formulary?
Cor from Base on these Meds

What formulary drugs have been tried? What was outcome?
?, Meds these

Ordering Physician: PRINT NAME: Kelly York, ARNP

Ordering Physician Signature: [signature] Date: 8/13/13

DEA #: (required for controlled substances)

If it is imperative the medication be started ASAP, call the pharmacist directly, in advance of sending this form. 1-888-200-9060 Please note: Non-formulary drugs may not be kept as stock medications. Therefore, if a medication must be initiated immediately, please obtain medications from the back-up pharmacy until the medication is received from PharmaCorr, LLC.

Observations/Comments for Provider Feedback (e.g. does the Reviewer concur with the prescription, request additional information, or suggest consideration of alternates or other options?)

☐ Faxed to PharmaCorr, LLC
☐ Faxed to site for Physician review

Reviewer's Signature: Murray Young M.D. Date: 81513

☐ Non-formulary order forwarded to PharmaCorr ☐ Non-formulary order withdrawn

Ordering Physician Signature: _____ Date: _____

Telephone: ( ) _____

THIS FORM IS FOR TRACKING, INFORMATIONAL, AND FEEDBACK PURPOSES ONLY. IT IS NEITHER INTENDED, NOR SHOULD IT BE CONSTRUED, AS AN APPROVAL/DENIAL FORM. THE TREATING PHYSICIAN MUST MAKE ALL MEDICAL DECISIONS BASED UPON THE INDIVIDUAL PATIENT'S MEDICAL CONDITION AND HISTORY, AND THE PHYSICIAN'S PROFESSIONAL JUDGMENT, EDUCATIONAL EXPERIENCE, AND PROFESSIONAL CONSULTATIONS, IF APPLICABLE.

02/07

CC# 6344-

CORIZON
PHARMACORR, LLC
OKLAHOMA CITY FAX # 1-888-200-7774
INDIANAPOLIS FAX # 1-800-259-3066
NON-FORMULARY DRUG TRACKING FORM

Date: 1/28/14 Institution: ICI-O Unit: BL

Inmate Name: Edmo, Mason Inmate ID#: 94691 DOB: [redacted]

Diagnosis: GID Allergies: NKDA

Past Medical History:

1) Drug: Estrace 2mg PO QD Refill Y/N Sig x ~~120~~ 90 days

2) Drug: provera 5mg Refill Y/N Sig PO QD x 90 Days

Medications in use: Zoloft, ASA, calcium, spironolactone

Note: Maximum of 90 day stop date on all non-formulary drugs.

If profile only check ☐ Yes (Medication will not be sent)

Why must this drug be used instead of one included on the formulary?
Risk of cardiovascular issues if estrogen level goes too high c̄ changing meds from what is working.

What formulary drugs have been tried? What was outcome?
see above.

Ordering Physician: PRINT NAME Anthony Bushnell, PA-C

Ordering Physician Signature [signature] PA-C Date: 1/28/14

DEA #: MB 3295191 (required for controlled substances)

If it is imperative the medication be started ASAP, call the pharmacist directly, in advance of sending this form. 1-888-200-9060
Please note: Non-formulary drugs may not be kept as stock medications. Therefore, if a medication must be initiated immediately, please obtain medications from the back-up pharmacy until the medication is received from PharmaCorr, LLC.

Observations/Comments for Provider Feedback (e.g. does the Reviewer concur with the prescription, request additional information, or suggest consideration of alternates or other options?)

☐ Faxed to PharmaCorr, LLC
☐ Faxed to site for Physician review

Reviewer's Signature murray young md Date 2314

☐ Non-formulary order forwarded to PharmaCorr ☐ Non-formulary order withdrawn

Ordering Physician Signature: ____________ Date: ____________

Telephone: ( ) ____________

THIS FORM IS FOR TRACKING, INFORMATIONAL, AND FEEDBACK PURPOSES ONLY. IT IS NEITHER INTENDED, NOR SHOULD IT BE CONSTRUED, AS AN APPROVAL/DENIAL FORM. THE TREATING PHYSICIAN MUST MAKE ALL MEDICAL DECISIONS BASED UPON THE INDIVIDUAL PATIENT'S MEDICAL CONDITION AND HISTORY, AND THE PHYSICIAN'S PROFESSIONAL JUDGMENT, EDUCATIONAL EXPERIENCE, AND PROFESSIONAL CONSULTATIONS, IF APPLICABLE.

02/07

CCI# 6340-[ ]

CORRECTIONAL MEDICAL SERVICES, INC.
PHARMACORR, LLC
OKLAHOMA CITY FAX # 1-888-200-7774
INDIANAPOLIS FAX # 1-800-259-3066
NON-FORMULARY DRUG TRACKING FORM

Date: 3/6/14 Institution: Idaho State Correctional Institution Unit:

Inmate Name: Edmo, Mason Inmate ID#: 94691 DOB: [redacted]

Diagnosis: Gender dysphoria Allergies: NKDA
Past Medical History:

1) Drug: Proscar 5mg Refill ☒N Sig 1 po daily - Okay x 90 days
order to start 3/6/14 4-5-14

2) Drug: Estradiol Refill ☒N Sig 3 mg po daily x 90 Days
Medications in use: Dose adjustment

Note: Maximum of 90 day stop date on all non-formulary drugs.

If profile only check ☐Yes (Medication will not be sent)

Why must this drug be used instead of one included on the formulary?

What formulary drugs have been tried? What was outcome?

Ordering Physician: PRINT NAME Cathy Whinnery, M.D. Date: 3/6/14
Ordering Physician Signature
DEA #: (required for controlled substances)

If it is imperative the medication be started ASAP, call the pharmacist directly, in advance of sending this form. 1-888-200-9060
Please note: Non-formulary drugs may not be kept as stock medications. Therefore, if a medication must be initiated immediately, please obtain medications from the back-up pharmacy until the medication is received from PharmaCorr, LLC.

Observations/Comments for Provider Feedback (e.g. does the Reviewer concur with the prescription, request additional information, or suggest consideration of alternates or other options?)

☐ Faxed to PharmaCorr, LLC
☐ Faxed to site for Physician review

Reviewer's Signature Dr. Murray Young, RMD Date 3/7/14
☐ Non-formulary order forwarded to PharmaCorr ☐ Non-formulary order withdrawn

Ordering Physician Signature: _____ Date: _____
Telephone: ( ) _____

THIS FORM IS FOR TRACKING, INFORMATIONAL, AND FEEDBACK PURPOSES ONLY. IT IS NEITHER INTENDED, NOR SHOULD IT BE CONSTRUED, AS AN APPROVAL/DENIAL FORM. THE TREATING PHYSICIAN MUST MAKE ALL MEDICAL DECISIONS BASED UPON THE INDIVIDUAL PATIENT'S MEDICAL CONDITION AND HISTORY, AND THE PHYSICIAN'S PROFESSIONAL JUDGMENT, EDUCATIONAL EXPERIENCE, AND PROFESSIONAL CONSULTATIONS, IF APPLICABLE.

02/07

CCI# 6340-[ ]

CORRECTIONAL MEDICAL SERVICES, INC.
PHARMACORR, LLC
OKLAHOMA CITY FAX # 1-888-200-7774
INDIANAPOLIS FAX # 1-800-259-3066
NON-FORMULARY DRUG TRACKING FORM

Date: 3/17/14 Institution: Idaho State Correctional Institution Unit:

Inmate Name: Edmo, Mason Inmate ID#: 94691 DOB: [redacted]

Diagnosis: Gender dysphoria Allergies: NKDA
Past Medical History:

1) Drug: Proscar 5mg Refill Y/N Sig 1 PO daily x 90 days

2) Drug: Refill Y/N Sig ★ Start 4-5-14 x Days

Medications in use:

Note: Maximum of 90 day stop date on all non-formulary drugs.

If profile only check ☐ Yes (Medication will not be sent)

Why must this drug be used instead of one included on the formulary?

What formulary drugs have been tried? What was outcome?

Ordering Physician: PRINT NAME Dr. Murray Young, RMD
Ordering Physician Signature
DEA #: Date: 3/25/14 (required for controlled substances)

If it is imperative the medication be started ASAP, call the pharmacist directly, in advance of sending this form. 1-888-200-9060
Please note: Non-formulary drugs may not be kept as stock medications. Therefore, if a medication must be initiated immediately, please obtain medications from the back-up pharmacy until the medication is received from PharmaCorr, LLC.

Observations/Comments for Provider Feedback (e.g. does the Reviewer concur with the prescription, request additional information, or suggest consideration of alternates or other options?)

☐ Faxed to PharmaCorr, LLC
☐ Faxed to site for Physician review

Reviewer's Signature Dr. Murray Young, RMD Date 3/25/14
☐ Non-formulary order forwarded to PharmaCorr ☐ Non-formulary order withdrawn

Ordering Physician Signature: _____ Date: _____
Telephone: ( ) _____

THIS FORM IS FOR TRACKING, INFORMATIONAL, AND FEEDBACK PURPOSES ONLY. IT IS NEITHER INTENDED, NOR SHOULD IT BE CONSTRUED, AS AN APPROVAL/DENIAL FORM. THE TREATING PHYSICIAN MUST MAKE ALL MEDICAL DECISIONS BASED UPON THE INDIVIDUAL PATIENT'S MEDICAL CONDITION AND HISTORY, AND THE PHYSICIAN'S PROFESSIONAL JUDGMENT, EDUCATIONAL EXPERIENCE, AND PROFESSIONAL CONSULTATIONS, IF APPLICABLE.

02/07

CC# 6340-[ ]

CORRECTIONAL MEDICAL SERVICES, INC
PHARMACORR, LLC
OKLAHOMA CITY FAX # 1-888-200-7774
INDIANAPOLIS FAX # 1-800-259-3066
NON-FORMULARY DRUG TRACKING FORM

NF

Date: Institution: Unit:

Inmate Name: Marcos Eduardo Inmate ID#: 94691 DOB: [redacted]

Diagnosis: GID Allergies: NKDA
Past Medical History

1) Drug: Estradiol 1mg Refill Y/N Sig 1 PO QD x 90 days

2) Drug: Proscar 5mg Refill Y/N Sig 1 PO QD x 90 Days

Medications in use:

Note: Maximum of 90 day stop date on all non-formulary drugs.

If profile only check ☐ Yes (Medication will not be sent)

Why must this drug be used instead of one included on the formulary?

What formulary drugs have been tried? What was outcome?

Ordering Physician: PRINT NAME William Poulson NP-C
Ordering Physician Signature
DEA #:

Date: 6/5/14
(required for controlled substances)

If it is imperative the medication be started ASAP, call the pharmacist directly, in advance of sending this form. 1-888-200-9060
Please note: Non-formulary drugs may not be kept as stock medications. Therefore, if a medication must be initiated immediately, please obtain medications from the back-up pharmacy until the medication is received from PharmaCorr, LLC.

Observations/Comments for Provider Feedback (e.g. does the Reviewer concur with the prescription, request additional information, or suggest consideration of alternates or other options?)

☐ Faxed to PharmaCorr, LLC
☐ Faxed to site for Physician review

Reviewer's Signature Dr. Mary Young, FMD Date 6/11/14
☐ Non-formulary order forwarded to PharmaCorr ☐ Non-formulary order withdrawn

Ordering Physician Signature: _____ Date: _____
Telephone: ( ) _____

THIS FORM IS FOR TRACKING, INFORMATIONAL, AND FEEDBACK PURPOSES ONLY. IT IS NEITHER INTENDED, NOR SHOULD IT BE CONSTRUED, AS AN APPROVAL/DENIAL FORM. THE TREATING PHYSICIAN MUST MAKE ALL MEDICAL DECISIONS BASED UPON THE INDIVIDUAL PATIENT'S MEDICAL CONDITION AND HISTORY, AND THE PHYSICIAN'S PROFESSIONAL JUDGMENT, EDUCATIONAL EXPERIENCE, AND PROFESSIONAL CONSULTATIONS, IF APPLICABLE.

02/07

CC# 6340-

CORRECTIONAL MEDICAL SERVICES, INC.
PHARMACORR, LLC
OKLAHOMA CITY FAX # 1-888-200-7774
INDIANAPOLIS FAX # 1-800-259-3066
NON-FORMULARY DRUG TRACKING FORM

Date: 7/3/14 Institution: Idaho State Correctional Institution Unit:

Inmate Name: Edmo, Mason Inmate ID#: 94691 DOB: [redacted]

Diagnosis: GID Allergies: NKDA
Past Medical History :

1) Drug: Estradiol Refill Y/N Sig 3 mg po daily x 90 days

2) Drug: Refill Y/N Sig This order x Days
to stop 8/2/14

Medications in use:

Note: Maximum of 90 day stop date on all non-formulary drugs.

If profile only check ☐ Yes (Medication will not be sent)

Why must this drug be used instead of one included on the formulary?

What formulary drugs have been tried? What was outcome?

Ordering Physician: PRINT NAME C. Whinnery, M.D. Date: 7/3/14
Ordering Physician Signature
DEA #: (required for controlled substances)

If it is imperative the medication be started ASAP, call the pharmacist directly, in advance of sending this form. 1-888-200-9060
Please note: Non-formulary drugs may not be kept as stock medications. Therefore, if a medication must be initiated immediately, please obtain medications from the back-up pharmacy until the medication is received from PharmaCorr, LLC.

Observations/Comments for Provider Feedback (e.g. does the Reviewer concur with the prescription, request additional information, or suggest consideration of alternates or other options?)

☐ Faxed to PharmaCorr, LLC
☐ Faxed to site for Physician review

Reviewer's Signature Dr. Murray Young, RMD Date 7/8/14
☐ Non-formulary order forwarded to PharmaCorr ☐ Non-formulary order withdrawn

Ordering Physician Signature: _____ Date: _____
Telephone: ( ) _____

THIS FORM IS FOR TRACKING, INFORMATIONAL, AND FEEDBACK PURPOSES ONLY. IT IS NEITHER INTENDED, NOR SHOULD IT BE CONSTRUED, AS AN APPROVAL/DENIAL FORM. THE TREATING PHYSICIAN MUST MAKE ALL MEDICAL DECISIONS BASED UPON THE INDIVIDUAL PATIENT'S MEDICAL CONDITION AND HISTORY, AND THE PHYSICIAN'S PROFESSIONAL JUDGMENT, EDUCATIONAL EXPERIENCE, AND PROFESSIONAL CONSULTATIONS, IF APPLICABLE.

CC# 6340-[ ]

CORRECTIONAL MEDICAL SERVICES, INC.
PHARMACORR, LLC
OKLAHOMA CITY FAX # 1-888-200-7774
INDIANAPOLIS FAX # 1-800-259-3066
NON-FORMULARY DRUG TRACKING FORM

Date: 10/8/14 Institution: Idaho State Correctional Institution Unit: [redacted]

Inmate Name: Edmo, Mason Inmate ID#: 94691 DOB: [redacted]

Diagnosis: GID Allergies: NKDA
Past Medical History:

1) Drug: Estradiol 1mg Refill Y/N Sig 3mg po daily Start 10/31/14 x 90 days

2) Drug: Prosca 5mg Refill Y/N Sig 1 po daily x 90 Days

Medications in use:

Note: Maximum of 90 day stop date on all non-formulary drugs.

If profile only check ☐ Yes (Medication will not be sent)

Why must this drug be used instead of one included on the formulary?

What formulary drugs have been tried? What was outcome?

Ordering Physician: PRINT NAME E. Whinnery, M.D. Date: 10/8/14
Ordering Physician Signature
DEA #: (required for controlled substances)

If it is imperative the medication be started ASAP, call the pharmacist directly, in advance of sending this form. 1-888-200-9060
Please note: Non-formulary drugs may not be kept as stock medications. Therefore, if a medication must be initiated immediately, please obtain medications from the back-up pharmacy until the medication is received from PharmaCorr, LLC.

Observations/Comments for Provider Feedback (e.g. does the Reviewer concur with the prescription, request additional information, or suggest consideration of alternates or other options?)

☐ Faxed to PharmaCorr, LLC
☐ Faxed to site for Physician review

Reviewer's Signature Dr. Murray Young, RMD Date 10/14/14
☐ Non-formulary order forwarded to PharmaCorr ☐ Non-formulary order withdrawn

Ordering Physician Signature: _____ Date: _____
Telephone: ( ) _____

THIS FORM IS FOR TRACKING, INFORMATIONAL, AND FEEDBACK PURPOSES ONLY. IT IS NEITHER INTENDED, NOR SHOULD IT BE CONSTRUED, AS AN APPROVAL/DENIAL FORM. THE TREATING PHYSICIAN MUST MAKE ALL MEDICAL DECISIONS BASED UPON THE INDIVIDUAL PATIENT'S MEDICAL CONDITION AND HISTORY, AND THE PHYSICIAN'S PROFESSIONAL JUDGMENT, EDUCATIONAL EXPERIENCE, AND PROFESSIONAL CONSULTATIONS, IF APPLICABLE.

02/07

CC# 6340-[ ]

CORRECTIONAL MEDICAL SERVICES, INC.
PHARMACORR, LLC
OKLAHOMA CITY FAX # 1-888-200-7774
INDIANAPOLIS FAX # 1-800-259-3066
NON-FORMULARY DRUG TRACKING FORM

Date: 1-8-15 Institution: Idaho State Correctional Institution Unit:

Inmate Name: Edwin Mason Inmate ID#: 94691 DOB: [redacted]

Diagnosis: GID
Past Medical History:

Allergies:

1) Drug: Estradiol 2mg po qd - this order to start 1/29/15 Refill Y/N Sig x 90 days

2) Drug: Proscar 5mg Refill Y/N Sig 1 po daily x 90 Days

Medications in use:

Note: Maximum of 90 day stop date on all non-formulary drugs.

If profile only check ☐ Yes (Medication will not be sent)

Why must this drug be used instead of one included on the formulary?

What formulary drugs have been tried? What was outcome?

Ordering Physician: PRINT NAME C. Whinery, M.D.
Ordering Physician Signature
DEA #: Date: 1/8/15 (required for controlled substances)

If it is imperative the medication be started ASAP, call the pharmacist directly, in advance of sending this form. 1-888-200-9060
Please note: Non-formulary drugs may not be kept as stock medications. Therefore, if a medication must be initiated immediately, please obtain medications from the back-up pharmacy until the medication is received from PharmaCorr, LLC.

Observations/Comments for Provider Feedback (e.g. does the Reviewer concur with the prescription, request additional information, or suggest consideration of alternates or other options?)

☐ Faxed to PharmaCorr, LLC
☐ Faxed to site for Physician review

Reviewer's Signature Dr. Murray Young, RMD Date 1/13/15
☐ Non-formulary order forwarded to PharmaCorr ☐ Non-formulary order withdrawn

Ordering Physician Signature: _____ Date: _____
Telephone: ( ) _____

THIS FORM IS FOR TRACKING, INFORMATIONAL, AND FEEDBACK PURPOSES ONLY. IT IS NEITHER INTENDED, NOR SHOULD IT BE CONSTRUED, AS AN APPROVAL/DENIAL FORM. THE TREATING PHYSICIAN MUST MAKE ALL MEDICAL DECISIONS BASED UPON THE INDIVIDUAL PATIENT'S MEDICAL CONDITION AND HISTORY, AND THE PHYSICIAN'S PROFESSIONAL JUDGMENT, EDUCATIONAL EXPERIENCE, AND PROFESSIONAL CONSULTATIONS, IF APPLICABLE.

02/07

ID# 6340

CORRECTIONAL MEDICAL SER[illegible]
PHARMACORR, LLC
OKLAHOMA CITY FAX # 1-888-200-7774
INDIANAPOLIS FAX # 1-800-259-3066
NON-FORMULARY DRUG TRACKING FORM

Date: 4-6-15 Institution: Idaho State Correctional Institution Unit:

Inmate Name: Edno, Mason Inmate ID#: 94691 DOB: [redacted]

Diagnosis:
Past Medical History:

Allergies: NKDA

1) Drug: Estradiol 3mg Refill Y/N Sig p.o.q.d. x 90 days

2) Drug: Proscar 5mg Refill Y/N Sig p.o.q.d. x 90 Days

Medications in use:

Note: Maximum of 90 day stop date on all non-formulary drugs.

If profile only check ☐ Yes (Medication will not be sent)

Why must this drug be used instead of one included on the formulary?

What formulary drugs have been tried? What was outcome?

Ordering Physician: PRINT NAME William Poulson, NP
Ordering Physician Signature
DEA #: APR 06 2015 Date:
(required for controlled substances)

If it is imperative the medication be started ASAP, call the pharmacist directly, in advance of sending this form. 1-888-200-9060
Please note: Non-formulary drugs may not be kept as stock medications. Therefore, if a medication must be initiated immediately, please obtain medications from the back-up pharmacy until the medication is received from PharmaCorr, LLC.

Observations/Comments for Provider Feedback (e.g. does the reviewer concur with the prescription, request additional information, or suggest consideration of alternates or other options?)

☐ Faxed to PharmaCorr, LLC
☐ Faxed to site for Physician review

Reviewer's Signature TR David Agler, M.D. Date 4/5/15
☑ Non-formulary order forwarded to PharmaCorr ☐ Non-formulary order withdrawn

Ordering Physician Signature: _____ Date: _____
Telephone: ( ) _____

THIS FORM IS FOR TRACKING, INFORMATIONAL, AND FEEDBACK PURPOSES ONLY. IT IS NEITHER INTENDED, NOR SHOULD IT BE CONSTRUED, AS AN APPROVAL/DENIAL FORM. THE TREATING PHYSICIAN MUST MAKE ALL MEDICAL DECISIONS BASED UPON THE INDIVIDUAL PATIENT'S MEDICAL CONDITION AND HISTORY, AND THE PHYSICIAN'S PROFESSIONAL JUDGMENT, EDUCATIONAL EXPERIENCE, AND PROFESSIONAL CONSULTATIONS, IF APPLICABLE.

02/07

CC# 6340-

CORRECTIONAL MEDICAL SERVICES, INC.
PHARMACORR, LLC
OKLAHOMA CITY FAX # 1-888-200-7774
INDIANAPOLIS FAX # 1-800-259-3066
NON-FORMULARY DRUG TRACKING FORM

Date: 6/26/15 Institution: Idaho State Correctional Institution Unit:

Inmate Name: Edmo, Mason Inmate ID#: 94691 DOB: [redacted]

Diagnosis: GID Allergies:
Past Medical History :

1) Drug: Estrace 1mg Refill Y/N Sig #ii PO QD x 90 days

2) Drug: Proscar 5mg Refill Y/N Sig #i PO QD x 90 Days

Medications in use:

Note: Maximum of 90 day stop date on all non-formulary drugs.

If profile only check ☐ Yes (Medication will not be sent)

Why must this drug be used instead of one included on the formulary?

What formulary drugs have been tried? What was outcome?

Ordering Physician: PRINT NAME Christian Gentry, MD
Ordering Physician Signature 1088 JUN 26 2015
DEA #: Date:
(required for controlled substances)

If it is imperative the medication be started ASAP, call the pharmacist directly, in advance of sending this form. 1-888-200-9060
Please note: Non-formulary drugs may not be kept as stock medications. Therefore, if a medication must be initiated immediately, please obtain medications from the back-up pharmacy until the medication is received from PharmaCorr, LLC.

Observations/Comments for Provider Feedback (e.g. does the Reviewer concur with the prescription, request additional information, or suggest consideration of alternates or other options?)

☐ Faxed to PharmaCorr, LLC
☐ Faxed to site for Physician review

Reviewer's Signature Dr. Murray Young, RMD Date 6/30/15
☐ Non-formulary order forwarded to PharmaCorr ☐ Non-formulary order withdrawn

Ordering Physician Signature: _____ Date: _____
Telephone: ( ) _____

THIS FORM IS FOR TRACKING, INFORMATIONAL, AND FEEDBACK PURPOSES ONLY. IT IS NEITHER INTENDED, NOR SHOULD IT BE CONSTRUED, AS AN APPROVAL/DENIAL FORM. THE TREATING PHYSICIAN MUST MAKE ALL MEDICAL DECISIONS BASED UPON THE INDIVIDUAL PATIENT'S MEDICAL CONDITION AND HISTORY, AND THE PHYSICIAN'S PROFESSIONAL JUDGMENT, EDUCATIONAL EXPERIENCE, AND PROFESSIONAL CONSULTATIONS, IF APPLICABLE.

02/07

CORIZON
Promote a culture of safety

Review
Non-Formulary Process
with Practitioner

Non-Formulary **Pharmacy** Request Forms

Form must be complete and legible. **You must Type or Print.**

*Site Name and Number: ISCI 6340	*Site Phone 208 424 3726	*Site Fax #: 208 338 0085
*Patient Name (Last, First): Edmo Mason	*Date of Birth: [redacted]	*Sex: ● Male ○ Female
*ID #: 94691	Date of Incarceration:	Expected Date of Release:

*Diagnosis:

*Medication Allergies: NKDA

*Requested Non-Formulary Medication and Strength: Estradiol 1mg tab

*Directions: 1 1/2 tabs po qd @ campbell

*Duration of Therapy: (Maximum duration: Jails 30 days; Prisons 90 days) ○ 7 days ○ 10 days ○ 14 days ○ 21 days ○ 30 days ● Other: 90 days ☐ Profile only (medication will not be sent)

*Justification for this non-formulary medication. Include what formulary medications have been tried and the outcome

- ☑ Renewal of previously approved non-formulary medication Explain:
- ☐ Patient is allergic/intolerant to medication on formulary Explain:
- ☐ Formulary medication has been tried and is ineffective - List: Explain:
- ☐ Patient has significant medical problem unresponsive to formulary medication Explain:
- ☐ No comparable medication on formulary Explain:

*Renewal of subsequent order compliance (Determined by Review of MAR): ○ >80% ○ <80%

*Practitioner Information: ○ Physician ● NP / PA ○ Dentist ○ Psychiatrist

*Name: William Poulson, NP *Signature

*Daytime Phone: SEP 24 2015 *Pager/Cell Number:

Site Medical Director
- ☐ Approved as Requested
- ☐ Approved with Modifications
- ☐ Alternative Treatment Recommended

*Explanation/Recommendation:

*Print Name:
*Signature:
*Date:

Regional Medical Director
- ☑ Approved as Requested
- ☐ Approved with Modifications
- ☐ Alternative Treatment Recommended

*Explanation/Recommendation:

*Print Name:
*Signature: Dr. Murray Young, RMD
*Date: 9/25/15

*Required fields.

CS2607

pharm

CORIZON
Promote a culture of safety

Subject Matter Expert: Review Non-Formulary Process with Practitioner

Non-Formulary **Pharmacy** Request Forms

Form must be complete and legible. **You must Type or Print.**

*Site Name and Number: ISCI 6340	*Site Phone 208 424 3726	*Site Fax #: 208 338 0085
*Patient Name (Last, First): Edmo, Mason	*Date of Birth:	*Sex: ● Male ○ Female
*ID #: 94691	Date of Incarceration:	Expected Date of Release:
*Diagnosis: Gender Dysphoria		
*Medication Allergies: NKDA		
*Requested Non-Formulary Medication and Strength: Estradiol 2mg tabs		
*Directions: ii PO QAM (4mg)		

***Duration of Therapy:** (Maximum duration: Jails 30 days; Prisons 90 days) ○ 7 days ○ 10 days ○ 14 days ○ 21 days ○ 30 days ✓ Other: 90 days ☐ Profile only (medication will not be sent)

***Justification for this non-formulary medication. Include what formulary medications have been tried and the outcome**

- ☐ Renewal of previously approved non-formulary medication Explain: Total E 137 pg/ml } on 3 mg/day
- ☐ Patient is allergic/intolerant to medication on formulary Explain: Estradiol 36 pg/ml }
- ☐ Formulary medication has been tried and is ineffective - List: Explain: Pt. weight = 205, dose, may
- ☐ Patient has significant medical problem unresponsive to formulary medication Explain: need ↑ dose
- ☒ No comparable medication on formulary Explain:

***Renewal of subsequent order compliance** (Determined by Review of MAR): ○ >80% ○ <80%

***Practitioner Information:** ○ Physician ✓ NP / PA ○ Dentist ○ Psychiatrist

***Name:** William Poulson, NP ***Signature** [signature]

***Daytime Phone:** OCT 08 2015 ***Pager/Cell Number:**

***Site Medical Director**	***Regional Medical Director**
☐ Approved as Requested	☑ Approved as Requested
☐ Approved with Modifications	☐ Approved with Modifications
☐ Alternative Treatment Recommended	☐ Alternative Treatment Recommended
***Explanation/Recommendation:**	***Explanation/Recommendation:**
***Print Name:**	***Print Name:**
***Signature:**	***Signature:** Dr. Murray Young, RMD
***Date:**	***Date:** 10/14/15

***Required fields.**

CS2607

pharm

Site Name and Number: 2084243726 208 338 00

Patient Name (last, first): Edmo, Mason. [redacted]

ID #: 94691 Expected Date of Release:

Diagnosis: Gender Dysphoria

*Medication Allergies: NKDA

*Requested Non-Formulary Medication and Strength: Proscar 5mg

*Directions: T po QD x90d

*Duration of Therapy: (Maximum duration: Jails 30 days; Prisons 90 days) ○ 7 days ○ 10 days ○ 14 days ○ 21 days ○ 30 days ☒ Other: 90 days ☐ Profile only (medication will not be ser

*Justification for this non-formulary medication. Include what formulary medications have been tried and the outcome

☒ Renewal of previously approved non-formulary medication Explain: approved multiple times

☐ Patient is allergic/intolerant to medication on formulary Explain:

☐ Formulary medication has been tried and is ineffective - List: Explain:

☐ Patient has significant medical problem unresponsive to formulary medication Explain:

☐ No comparable medication on formulary Explain:

*Renewal of subsequent order compliance (Determined by Review of MAR): ○ >80% ○ <80%

*Practitioner Information: ○ Physician ○ NP / PA ○ Dentist ○ Psychiatrist

*Name: Daniel Barry, PA-C *Signature: DBarry

*Daytime Phone: NOV 05 2015 *Pager/Cell Number:

*Site Medical Director	*Regional Medical Director
☐ Approved as Requested	☒ Approved as Requested
*Print Name:	*Print Name: David Ayer, MD
*Signature:	*Signature:
*Date:	*Date: 11/5/15

*Required fields.

CS2607

Pharmacy

*Site Name and Number: [illegible] | *Site Phone: [illegible] | Site Fax #: [illegible]

Patient Name (Last, First): Edmo Mason | Date of Birth: [redacted] | Sex: ☒ Male ☐ Female

*ID #: 9469 | Date of Incarceration: | Expected Date of Release:

*Diagnosis:

*Medication Allergies: NKDA

*Requested Non-Formulary Medication and Strength: Estrace 4mg

*Directions: po qam Start 1-7-16

*Duration of Therapy: (Maximum duration: Jails 30 days; Prisons 90 days) ☐ 7 days ☐ 10 days ☐ 14 days ☐ 21 days ☐ 30 days ☒ Other: 90d days ☐ Profile only (medication will not be sent)

*Justification for this non-formulary medication. Include what formulary medications have been tried and the outcome

☒ Renewal of previously approved non-formulary medication Explain:

☐ Patient is allergic/intolerant to medication on formulary Explain:

☐ Formulary medication has been tried and is ineffective - List: Explain:

☐ Patient has significant medical problem unresponsive to formulary medication Explain:

☐ No comparable medication on formulary Explain:

*Renewal of subsequent order compliance (Determined by Review of MAR): ☐ ≥ 80% ☐ < 80%

*Practitioner Information: ☐ Physician ☒ NP / PA ☐ Dentist ☐ Psychiatrist

*Name: William Poulson, NP Signature:

*Daytime Phone: DEC 23 2015 *Pager/Cell Number:

*Site Medical Director	*Regional Medical Director
☐ Approved as Requested	☐ Approved as Requested
☐ Approved with Modifications	☐ Approved with Modifications
☐ Alternative Treatment Recommended	☐ Alternative Treatment Recommended
Explanation/Recommendation:	Explanation/Recommendation:
*Print Name:	*Print Name: Dr. Murray Young, RMD
*Signature:	*Signature:
*Date:	*Date: 12/28/15

*Required fields.

07

Pharm

Non-Formulary Pharmacy Request Form

Form must be complete and legible. You must type or print

*Site Name and Number: ISCI 6340	*Site Phone: 208 424 3720	*Site Fax #: 208 338 0085
*Patient Name (Last, First): Edmo, Mason	Date of Birth: [redacted]	*Sex: ☒ Male ☐ Female
*ID #: 94691	Date of Incarceration:	Expected Date of Release:

*Diagnosis: GD

*Medication Allergies:

***Requested Non-Formulary Medication and Strength:** Proscar 5mg

***Directions:** i PO QD

***Duration of Therapy:** (Maximum duration: Jails 30 days; Prisons 90 days) ☐ 7 days ☐ 10 days ☐ 14 days ☐ 21 days ☐ 30 days ☒ Other: 90 days ☐ Profile only (medication will not be sent)

***Justification for this non-formulary medication. Include what formulary medications have been tried and the outcome**

☒ Renewal of previously approved non-formulary medication Explain:

☐ Patient is allergic/intolerant to medication on formulary Explain:

☐ Formulary medication has been tried and is ineffective - List: Explain:

☐ Patient has significant medical problem unresponsive to formulary medication Explain:

☐ No comparable medication on formulary Explain:

***Renewal of subsequent order compliance** (Determined by Review of MAR): ☐ > 80% ☐ < 80%

***Practitioner Information:** ☐ Physician ☒ NP / PA ☐ Dentist ☐ Psychiatrist

***Name:** William Poulson, NP *Signature: [signature]

***Daytime Phone:** DEC 23 2015 ***Pager/Cell Number:**

*Site Medical Director	*Regional Medical Director
☐ Approved as Requested	☒ Approved as Requested
☐ Approved with Modification	☐ Approved with Modification
Alternative Treatment Recommended	Alternative Treatment Recommended
*Explanation/Recommendation:	*Explanation/Recommendation:
*Print Name:	*Print Name:
*Signature:	*Signature: Dr. Murray Young, RMD
*Date:	*Date: 12/28/15

*Required fields.

07

CORIZON
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Subject Matter Expert: (
Review
Non-Formulary Process
with Practitioner

Non-Formulary **Pharmacy** Request Forms

Form must be complete and legible. You must Type or Print.

*Site Name and Number: ISCI 6340	*Site Phone 208 424 3726	*Site Fax #: 208 338 0085
*Patient Name (Last, First): Edmo, Mason	*Date of Birth [redacted]	*Sex: ● Male ○ Female
*ID #: 94691	Date of Incarceration:	Expected Date of Release:

*Diagnosis: GD

*Medication Allergies: NKDA

*Requested Non-Formulary Medication and Strength: Estrace 4mg Start 4-7-16

*Directions: po qam

*Duration of Therapy: (Maximum duration: Jails 30 days; Prisons 90 days) ○ 7 days ○ 10 days ○ 14 days ○ 21 days ○ 30 days ○ Other: _____ days ☐ Profile only (medication will not be sent)

*Justification for this non-formulary medication. Include what formulary medications have been tried and the outcome

- ☑ Renewal of previously approved non-formulary medication Explain: _____
- ☐ Patient is allergic/intolerant to medication on formulary Explain: _____
- ☐ Formulary medication has been tried and is ineffective - List: Explain: _____
- ☐ Patient has significant medical problem unresponsive to formulary medication Explain: _____
- ☑ No comparable medication on formulary Explain:

*Renewal of subsequent order compliance (Determined by Review of MAR): ○ >80% ○ <80%

*Practitioner Information: ● Physician ○ NP / PA ○ Dentist ○ Psychiatrist

*Name: David Agler, MD *Signature: [signature]

*Daytime Phone: _____ *Pager/Cell Number: _____

***Site Medical Director**
- ☑ Approved as Requested
- ☐ Approved with Modifications
- ☐ Alternative Treatment Recommended

*Explanation/Recommendation:

*Print Name: David Agler, MD
*Signature: [signature]
*Date: 3/16/16

***Regional Medical Director**
- ☐ Approved as Requested
- ☐ Approved with Modifications
- ☐ Alternative Treatment Recommended

*Explanation/Recommendation:

*Print Name: _____
*Signature: Dr. Murray Young, RMD
*Date: 3/17/16

*Required fields.

CS2607

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Subject Matter Expert:
Review
Non-Formulary Process
with Practitioner

Non-Formulary **Pharmacy** Request Forms

Form must be complete and legible. You must Type or Print.

*Site Name and Number: ISCI 6340	*Site Phone 208 424 3726	*Site Fax #: 208 338 0085
*Patient Name (Last, First): Edmo Mason	*Date of Birth: [redacted]	*Sex: ● Male ○ Female
*ID #: 94691	Date of Incarceration:	Expected Date of Release:

*Diagnosis: GD

*Medication Allergies: NKDA

*Requested Non-Formulary Medication and Strength: Prozac 5mg Start 3-28-16

*Directions: po qd

*Duration of Therapy: (Maximum duration: Jails 30 days; Prisons 90 days) ○ 7 days ○ 10 days ○ 14 days ○ 21 days ○ 30 days ☒ Other: 90 days ☐ Profile only (medication will not be sent)

*Justification for this non-formulary medication. Include what formulary medications have been tried and the outcome

- ☑ Renewal of previously approved non-formulary medication — Explain: Concurrent Estrogen use is additive.
- ☐ Patient is allergic/intolerant to medication on formulary — Explain:
- ☐ Formulary medication has been tried and is ineffective - List: — Explain:
- ☐ Patient has significant medical problem unresponsive to formulary medication — Explain:
- ☑ No comparable medication on formulary — Explain:

*Renewal of subsequent order compliance (Determined by Review of MAR): ○ >80% ○ <80%

*Practitioner Information: ○ Physician ○ NP / PA ○ Dentist ○ Psychiatrist

*Name: David Agler, MD *Signature: [signature]

*Daytime Phone: *Pager/Cell Number:

***Site Medical Director**
- ☑ Approved as Requested
- ☐ Approved with Modifications
- ☐ Alternative Treatment Recommended

*Explanation/Recommendation:

*Print Name: David Agler, MD
*Signature: [signature]
*Date: 3/16/16

***Regional Medical Director**
- ☐ Approved as Requested
- ☐ Approved with Modifications
- ☐ Alternative Treatment Recommended

*Explanation/Recommendation:

*Print Name:
*Signature: Dr. Murray Young, RMD
*Date: 3/17/16

*Required fields.

CS2607

CORIZON

Pharmacy Request Form

Must be complete and legible. You must Type or Print

*Site Name and Number: ISCI 6340	*Site Phone: 208 424 3726	*Site Fax #: 208 338 0085
*Patient Name (Last, First): Edmo, Mason	*Date of Birth: [redacted]	*Sex: ☉ Male ○ Female
*ID #: 94691	Date of Incarceration:	Expected Date of Release:

*Diagnosis: GD

*Medication Allergies: NKDA

*Requested Non-Formulary Medication and Strength: Estradiol 4 mg

*Directions: PO QD

*Duration of Therapy: (Maximum duration: Jails 30 days; Prisons 90 days) ○ 7 days ○ 10 days ○ 14 days ○ 21 days ○ 30 days ☑ Other: 90 days ☐ Profile only (medication will not be sent)

*Justification for this non-formulary medication. Include what formulary medications have been tried and the outcome

☑ Renewal of previously approved non-formulary medication Explain:

☐ Patient is allergic/intolerant to medication on formulary Explain:

☐ Formulary medication has been tried and is ineffective - List: Explain:

☐ Patient has significant medical problem unresponsive to formulary medication Explain:

☑ No comparable medication on formulary Explain:

*Renewal of subsequent order compliance (Determined by Review of MAR): ○ >80% ○ <80%

*Practitioner Information: ○ Physician ○ NP / PA ○ Dentist ○ Psychiatrist

*Name: David Agler, MD Signature: [signature]

*Daytime Phone: *Pager/Cell Number:

***Site Medical Director**

☑ Approved as Requested

☐ Approved with Modifications

☐ Alternative Treatment Recommended

*Explanation/Recommendation

*Print Name: David Agler, MD

*Signature: [signature]

*Date: 6/5/14

***Regional Medical Director**

☐ Approved as Requested

☐ Approved with Modifications

☐ Alternative Treatment Recommended

*Explanation/Recommendation

*Print Name:

*Signature:

*Date:

*Required fields.

2607

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Review
Non-Formulary Proc
with Practitioner

Non-Formulary **Pharmacy** Request Forms

Form must be complete and legible. You must Type or Print.

*Site Name and Number: ISCI 6340	*Site Phone 208 424 3726	*Site Fax #: 208 338 0085
*Patient Name (Last, First): Edmo Mason	*Date of Birth: [redacted]	*Sex: ● Male ○ Female
*ID #: 94691	Date of Incarceration:	Expected Date of Release:

*Diagnosis: GD

*Medication Allergies: NKDA

*Requested Non-Formulary Medication and Strength: Proscar 5mg

*Directions: poqd

*Duration of Therapy: (Maximum duration: Jails 30 days; Prisons 90 days) ○ 7 days ○ 10 days ○ 14 days ○ 21 days ○ 30 days ☑ Other: 90 days ☐ Profile only (medication will not be sent)

*Justification for this non-formulary medication. Include what formulary medications have been tried and the outcome

- ☑ Renewal of previously approved non-formulary medication — Explain: Concurrent Estrogen use in addition
- ☐ Patient is allergic/intolerant to medication on formulary — Explain:
- ☐ Formulary medication has been tried and is ineffective - List: — Explain:
- ☐ Patient has significant medical problem unresponsive to formulary medication — Explain:
- ☐ No comparable medication on formulary — Explain:

*Renewal of subsequent order compliance (Determined by Review of MAR): ○ >80% ○ <80%

*Practitioner Information: ○ Physician ○ NP / PA ○ Dentist ○ Psychiatrist

*Name: David Agler, MD *Signature: [signature]

*Daytime Phone: *Pager/Cell Number:

***Site Medical Director**
- ☑ Approved as Requested
- ☐ Approved with Modifications
- ☐ Alternative Treatment Recommended

*Explanation/Recommendation:

*Print Name: David Agler, MD
*Signature: [signature]
*Date: 6/27/16

***Regional Medical Director**
- ☑ Approved as Requested
- ☐ Approved with Modifications
- ☐ Alternative Treatment Recommended

*Explanation/Recommendation:

*Print Name: David Agler, MD
*Signature: [signature]
*Date: 6/27/16

*Required fields.

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Subject Matter Expert:
Review
Non-Formulary Process
with Practitioner

Non-Formulary Pharmacy Request Forms

Form must be complete and legible. You must Type or Print.

*Site Name and Number: ISCI 6340	*Site Phone 208 424 3726	*Site Fax #: 208 338 0085
*Patient Name (Last, First): Edmo Mason	*Date of Birth: [redacted]	*Sex: ● Male ○ Female
*ID #: 94691	Date of Incarceration:	Expected Date of Release:

*Diagnosis:

*Medication Allergies: NKDA

*Requested Non-Formulary Medication and Strength: Estradiol 4mg

*Directions: po qd

*Duration of Therapy: (Maximum duration: Jails 30 days; Prisons 90 days) ○ 7 days ○ 10 days ○ 14 days ○ 21 days ○ 30 days ● Other: 90d days ☐ Profile only (medication will not be sent)

*Justification for this non-formulary medication. Include what formulary medications have been tried and the outcome

- ☑ Renewal of previously approved non-formulary medication Explain:
- ☐ Patient is allergic/intolerant to medication on formulary Explain:
- ☐ Formulary medication has been tried and is ineffective - List: Explain:
- ☐ Patient has significant medical problem unresponsive to formulary medication Explain:
- ☐ No comparable medication on formulary Explain:

*Renewal of subsequent order compliance (Determined by Review of MAR): ○ > 80% ○ < 80%

*Practitioner Information: ○ Physician ● NP / PA ○ Dentist ○ Psychiatrist

*Name: Gabriel Dalmo, PA-C AUG 01 2016 *Signature

*Daytime Phone: *Pager/Cell Number:

Site Medical Director
- ☐ Approved as Requested
- ☐ Approved with Modifications
- ☐ Alternative Treatment Recommended

*Explanation/Recommendation:

*Print Name:
*Signature:
*Date:

Regional Medical Director
- ☑ Approved as Requested
- ☐ Approved with Modifications
- ☐ Alternative Treatment Recommended

*Explanation/Recommendation:

*Print Name:
*Signature: Rebekah M. Haggard, MD
*Date: 8/1/16

*Required fields.

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Non-Formulary **Pharmacy** Request Forms

Form must be complete and legible. You must Type or Print.

*Site Name and Number: ISCI 6340	*Site Phone 208 424 3726	*Site Fax #: 208 338 0085
*Patient Name (Last, First): EDMO, MASON	*Date of Birth: [redacted]	*Sex: ● Male ○ Female
*ID #: 94691	Date of Incarceration:	Expected Date of Release:
*Diagnosis: Gender Dysphoria Syndrome		
*Medication Allergies:		
*Requested Non-Formulary Medication and Strength: PROSCAR 5mg		
*Directions: 1 QD		

*Duration of Therapy: (Maximum duration: Jails 30 days; Prisons 90 days) ○ 7 days ○ 10 days ○ 14 days ○ 21 days ○ 30 days ○ Other: 90 DAYS days ☐ Profile only (medication will not be sent)

*Justification for this non-formulary medication. Include what formulary medications have been tried and the outcome

- ☒ Renewal of previously approved non-formulary medication Explain:
- ☐ Patient is allergic/intolerant to medication on formulary Explain:
- ☐ Formulary medication has been tried and is ineffective - List: Explain:
- ☐ Patient has significant medical problem unresponsive to formulary medication Explain:
- ☐ No comparable medication on formulary Explain:

*Renewal of subsequent order compliance (Determined by Review of MAR): ○ >80% ○ <80%

*Practitioner information: ● Physician ○ NP / PA ○ Dentist ○ Psychiatrist

*Name: [illegible] *Signature Matthew Sweetser, MD

*Daytime Phone: *Pager/Cell Number: 8/29/16 9 AM

*Site Medical Director	*Regional Medical Director
☐ Approved as Requested	☑ Approved as Requested
☐ Approved with Modifications	☐ Approved with Modifications
☐ Alternative Treatment Recommended	☐ Alternative Treatment Recommended
*Explanation/Recommendation:	*Explanation/Recommendation:
*Print Name:	*Print Name:
*Signature:	*Signature: Rebekah M. Haggard, MD
*Date:	*Date: 8/29/16

*Required fields.

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Subject Matter Expert:
Review
Non-Formulary Process
with Practitioner

Non-Formulary **Pharmacy** Request Forms

Form must be complete and legible. **You must Type or Print.**

*Site Name and Number: ISCI 6340	*Site Phone 2084243726	*Site Fax #: 208 338 0085
*Patient Name (Last, First): Edmo, Mason	*Date of Birth: [redacted]	*Sex: ● Male ○ Female
*ID #: 94691	Date of Incarceration:	Expected Date of Release:
*Diagnosis: G.D.		
*Medication Allergies: NKDA		
*Requested Non-Formulary Medication and Strength: Rasagiline 5 mg		
*Directions: PO QD		
*Duration of Therapy: (Maximum duration: Jails 30 days; Prisons 90 days) ○ 7 days ○ 10 days ○ 14 days ○ 21 days ○ 30 days ● Other: 90 days ☐ Profile only (medication will not be sent)		

*Justification for this non-formulary medication. Include what formulary medications have been tried and the outcome

- ☐ Renewal of previously approved non-formulary medication Explain:
- ☐ Patient is allergic/intolerant to medication on formulary Explain:
- ☐ Formulary medication has been tried and is ineffective - List: Explain:
- ☐ Patient has significant medical problem unresponsive to formulary medication Explain:
- ☑ No comparable medication on formulary Explain:

*Renewal of subsequent order compliance (Determined by Review of MAR): ○ >80% ○ <80%

*Practitioner Information: ○ Physician ○ NP / PA ○ Dentist ○ Psychiatrist

*Name: David Agler, MD *Signature: [signature]

*Daytime Phone: *Pager/Cell Number:

***Site Medical Director**
- ☑ Approved as Requested
- ☐ Approved with Modifications
- ☐ Alternative Treatment Recommended

*Explanation/Recommendation:

*Print Name: David Agler, MD
*Signature: [signature]
*Date: 9/8/16

***Regional Medical Director**
- ☑ Approved as Requested
- ☐ Approved with Modifications
- ☐ Alternative Treatment Recommended

*Explanation/Recommendation:

*Print Name:
*Signature: Rebekah M. Haggard, MD
*Date: 9/8/16

*Required fields.

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Subject Matter Expert:
Review
Non-Formulary Process
with Practitioner

Non-Formulary **Pharmacy** Request Forms

Form must be complete and legible. You must Type or Print.

*Site Name and Number: ISC1 6340	*Site Phone 208 424 3726	*Site Fax #: 208 338 0085
*Patient Name (Last, First): Edmo, Mason	*Date of Birth: [redacted]	*Sex: ● Male ○ Female
*ID #: 94691	Date of Incarceration:	Expected Date of Release:

*Diagnosis: G.D.

*Medication Allergies: NKDA

*Requested Non-Formulary Medication and Strength: Estradiol 6 mg

*Directions: PO QD

*Duration of Therapy: (Maximum duration: Jails 30 days; Prisons 90 days) ○ 7 days ○ 10 days ○ 14 days ○ 21 days ○ 30 days ● Other: 90 days ☐ Profile only (medication will not be sent)

*Justification for this non-formulary medication. Include what formulary medications have been tried and the outcome

- ☐ Renewal of previously approved non-formulary medication Explain:
- ☐ Patient is allergic/intolerant to medication on formulary Explain:
- ☐ Formulary medication has been tried and is ineffective - List: Explain:
- ☐ Patient has significant medical problem unresponsive to formulary medication Explain:
- ☑ No comparable medication on formulary Explain:

*Renewal of subsequent order compliance (Determined by Review of MAR): ○ >80% ○ <80%

*Practitioner Information: ○ Physician ○ NP / PA ○ Dentist ○ Psychiatrist

*Name: David Agler, MD *Signature: [signature]

*Daytime Phone: *Pager/Cell Number:

***Site Medical Director**
- ☑ Approved as Requested
- ☐ Approved with Modifications
- ☐ Alternative Treatment Recommended

*Explanation/Recommendation:

*Print Name: David Agler, MD
*Signature: [signature]
*Date: 9/8/16

***Regional Medical Director**
- ☐ Approved as Requested
- ☐ Approved with Modifications
- ☐ Alternative Treatment Recommended

*Explanation/Recommendation:

*Print Name:
*Signature:
*Date:

*Required fields.

CS2607

CORIZON HEALTH

Non-Formulary **Pharmacy** Request Forms

Form must be complete and legible. **You must Type or Print.**

Site Name and Number: ISCI 6340	Site Phone #: 2083360740	Site Fax #: 2083380085	
Patient Name (Last, First): Edmo, Mason	Date of Birth: [redacted]	Sex: ● Male ○ Female	
ID #: 94691	Date of Incarceration:	Expected Date of Release:	

Diagnosis:

Medication Allergies:

Requested Non-Formulary Medication and Strength: Estrace 6mg

Directions: po qd

Duration of Therapy: (Maximum duration: Jails 90 days; Prisons 90 days) ○ 7 days ○ 10 days ○ 14 days ○ 21 days ○ 30 days ○ 90 days ● Other: 90d days ☐ Profile only (medication will not be sent)

ePA number Obtained: ○ No ○ Yes ePA Number: Expiration Date:

Justification for this non-formulary medication. Include what formulary medications have been tried and the outcome

- ☑ Renewal of previously approved non-formulary medication Explain:
- ☐ Patient is allergic/intolerant to medication on formulary Explain:
- ☐ Formulary medication has been tried and is ineffective - List: Explain:
- ☐ Patient has significant medical problem unresponsive to formulary medication Explain:
- ☐ No comparable medication on formulary Explain:

Renewal of subsequent order compliance (Determined by Review of MAR): ○ > 80% ○ < 80%

Practitioner Information: ○ Physician ○ NP / PA ○ Dentist ○ Psychiatrist

Name: Signature

Daytime Phone: Pager/Cell Number: DEC 01 2016

Date:

Site Medical Director

- ☐ Approved as Requested
- ☐ Approved with Modifications
- ☐ Alternative Treatment Recommended

Explanation/Recommendation:

Print Name:

Signature:

Date:

Regional Medical Director

- ☐ Approved as Requested
- ☐ Approved with Modifications
- ☐ Alternative Treatment Recommended

Explanation/Recommendation:

Print Name:

Signature: Rebekah M. Haggard, MD

Date: 12/2/16

CS2607

CORIZON HEALTH

NF

Non-Formulary **Pharmacy** Request Forms

Form must be complete and legible. **You must Type or Print.**

Site Name and Number: ISCI 6340	Site Phone #: 2083360740	Site Fax #: 208 338 0085	
Patient Name (Last, First): Edmo, Mason	Date of Birth [redacted]	Sex: ● Male ○ Female	
ID #: 94691	Date of Incarceration:	Expected Date of Release:	
Diagnosis:			
Medication Allergies:			
Requested Non-Formulary Medication and Strength: Proscar 5mg			
Directions: po qd			
Duration of Therapy: (Maximum duration: Jails 90 days; Prisons 90 days) ○ 7 days ○ 10 days ○ 14 days ○ 21 days ○ 30 days ○ 90 days ● Other: 90d days ☐ Profile only (medication will not be sent)			
ePA number Obtained: ○ No ○ Yes	ePA Number:	Expiration Date:	

Justification for this non-formulary medication. Include what formulary medications have been tried and the outcome

- ☑ Renewal of previously approved non-formulary medication Explain: _____
- ☐ Patient is allergic/intolerant to medication on formulary Explain: _____
- ☐ Formulary medication has been tried and is ineffective - List: Explain: _____
- ☐ Patient has significant medical problem unresponsive to formulary medication Explain:
- ☐ No comparable medication on formulary Explain:

Renewal of subsequent order compliance (Determined by Review of MAR): ○ > 80% ○ < 80%

Practitioner Information: ○ Physician ○ NP / PA ○ Dentist ○ Psychiatrist

Name: _____ **Signature** _____ DEC 01 2016

Daytime Phone: _____ **Pager/Cell Number:** _____

Date: _____

Site Medical Director	Regional Medical Director
☐ Approved as Requested	☑ Approved as Requested
☐ Approved with Modifications	☐ Approved with Modifications
☐ Alternative Treatment Recommended	☐ Alternative Treatment Recommended
Explanation/Recommendation:	**Explanation/Recommendation:**
Print Name: _____	**Print Name:** _____
Signature: _____	**Signature:** Rebekah M. Haggard, MD
Date: _____	**Date:** 12/2/16

CS2607

CORIZON HEALTH

Non-Formulary **Pharmacy** Request Forms

Form must be complete and legible. You must Type or Print.

Site Name and Number: ISCI 6340	Site Phone #: 2083360740 Site Fax #: 2083380085
Patient Name (Last, First): Edmo, Mason	Date of Birth: [redacted] Sex: ● Male ○ Female
ID #: 94691	Date of Incarceration: Expected Date of Release:
Diagnosis:	
Medication Allergies:	
Requested Non-Formulary Medication and Strength:	medroxyprogesterone 10mg PO QD
Directions:	

Duration of Therapy: (Maximum duration: Jails 90 days; Prisons 90 days)
○ 7 days ○ 10 days ○ 14 days ○ 21 days ○ 30 days ☒ 90 days
○ Other: _____ days ☐ Profile only (medication will not be sent)

ePA number Obtained: ○ No ○ Yes ePA Number: Expiration Date:

Justification for this non-formulary medication. Include what formulary medications have been tried and the outcome

☐ Renewal of previously approved non-formulary medication Explain:
☐ Patient is allergic/intolerant to medication on formulary Explain:
☐ Formulary medication has been tried and is ineffective - List: Explain:
☐ Patient has significant medical problem unresponsive to formulary medication Explain:
☐ No comparable medication on formulary Explain:

Renewal of subsequent order compliance (Determined by Review of MAR): ○ > 80% ○ < 80%

Practitioner Information: ○ Physician ☒ NP / PA ○ Dentist ○ Psychiatrist

Name: Anthony Bushnell, PA-C Signature

Daytime Phone: Pager/Cell Number:

Date:

Site Medical Director
☐ Approved as Requested
☐ Approved with Modifications
☐ Alternative Treatment Recommended

Explanation/Recommendation:

Print Name:
Signature:
Date:

Regional Medical Director
☑ Approved as Requested
☐ Approved with Modifications
☐ Alternative Treatment Recommended

Explanation/Recommendation:

Print Name:
Signature: Rebekah M. Haggard, MD
Date: 12/20/16

CS2607

CORIZON HEALTH

NF

Non-Formulary **Pharmacy** Request Forms

Form must be complete and legible. **You must Type or Print.**

Site Name and Number: ISCI 6340	Site Phone #: 2083360740	Site Fax #: 208 338 0085	
Patient Name (Last, First): Edmo, Mason	Date of Birth: [redacted]	Sex: ● Male ○ Female	
ID #: 94671	Date of Incarceration:	Expected Date of Release:	
Diagnosis:			
Medication Allergies:			
Requested Non-Formulary Medication and Strength: Estrace 3mg PO BID crush x 90 days			
Directions:			
Duration of Therapy: (Maximum duration: Jails 90 days; Prisons 90 days) ○ 7 days ○ 10 days ○ 14 days ○ 21 days ○ 30 days ☒ 90 days ○ Other: _____ days ☐ Profile only (medication will not be sent)			
ePA number Obtained: ○ No ○ Yes	ePA Number:	Expiration Date:	

Justification for this non-formulary medication. Include what formulary medications have been tried and the outcome

- ☒ Renewal of previously approved non-formulary medication — Explain: _____
- ☐ Patient is allergic/intolerant to medication on formulary — Explain: _____
- ☐ Formulary medication has been tried and is ineffective - List: — Explain: _____
- ☐ Patient has significant medical problem unresponsive to formulary medication — Explain:
- ☐ No comparable medication on formulary — Explain:

Renewal of subsequent order compliance (Determined by Review of MAR): ○ > 80% ○ < 80%

Practitioner Information: ○ Physician ☑ NP / PA ○ Dentist ○ Psychiatrist

Name: Anthony Bushnell, PA-C **Signature** _____

Daytime Phone: _____ **Pager/Cell Number:** _____

Date: _____

Site Medical Director

- ☐ Approved as Requested
- ☐ Approved with Modifications
- ☐ Alternative Treatment Recommended

Explanation/Recommendation:

Print Name: _____

Signature: _____

Date: _____

Regional Medical Director

- ☑ Approved as Requested
- ☐ Approved with Modifications
- ☐ Alternative Treatment Recommended

Explanation/Recommendation:

Print Name: _____

Signature: Rebekah M. Haggard, MD

Date: 12/21/18

CS2607

CORIZON HEALTH

Non-Formulary **Pharmacy** Request Forms

Form must be complete and legible. You must Type or Print.

Site Name and Number: ISCI 6340	Site Phone #: 2083360740 Site Fax #: 2083380085
Patient Name (Last, First): Edmo, M	Date of Birth: [redacted] Sex: ● Male ○ Female
ID #: 94691	Date of Incarceration: Expected Date of Release:
Diagnosis: GD	
Medication Allergies: NKDA	
Requested Non-Formulary Medication and Strength: Estrace 3mg SL BID	
Directions: may use oral tab off label as SL per specialist	
Duration of Therapy: (Maximum duration: Jails 90 days; Prisons 90 days) ○ 7 days ○ 10 days ○ 14 days ○ 21 days ○ 30 days (90 days) ○ Other: _____ days ☐ Profile only (medication will not be sent)	
ePA number Obtained: ○ No ○ Yes ePA Number:	Expiration Date:

Justification for this non-formulary medication. Include what formulary medications have been tried and the outcome

- [X] Renewal of previously approved non-formulary medication Explain: _____
- [ ] Patient is allergic/intolerant to medication on formulary Explain: _____
- [ ] Formulary medication has been tried and is ineffective - List: Explain: _____
- [ ] Patient has significant medical problem unresponsive to formulary medication Explain:
- [ ] No comparable medication on formulary Explain:

Renewal of subsequent order compliance (Determined by Review of MAR): ○ > 80% ○ < 80%

Practitioner Information: ○ Physician ○ NP / PA ○ Dentist ○ Psychiatrist

Name: MValley PA-C Signature: MV

Daytime Phone: _____ Pager/Cell Number: _____

Date: 2/14/17

Site Medical Director	Regional Medical Director
☐ Approved as Requested	☑ Approved as Requested
☐ Approved with Modifications	☐ Approved with Modifications
☐ Alternative Treatment Recommended	☐ Alternative Treatment Recommended
Explanation/Recommendation:	Explanation/Recommendation:
Print Name:	Print Name:
Signature:	Signature: Rebekah Haggard
Date:	Date: 2/15/17

CS2607

CORIZON HEALTH

Non-Formulary **Pharmacy** Request Forms

Form must be complete and legible. **You must Type or Print.**

Site Name and Number: ISCI 6340	Site Phone #: 2083360740 Site Fax #: 208 338 0085
Patient Name (Last, First): Espino, MASON	Date of Birth: [redacted] Sex: ● Male ○ Female
ID #: 94691	Date of Incarceration: Expected Date of Release:
Diagnosis:	
Medication Allergies: NKDA	
Requested Non-Formulary Medication and Strength: FINASTERIDE 5 mg	
Directions: 1 tab PO Qday	
Duration of Therapy: (Maximum duration: Jails 90 days; Prisons 90 days) ○ 7 days ○ 10 days ○ 14 days ○ 21 days ○ 30 days ☒ 90 days ○ Other: _____ days ☐ Profile only (medication will not be sent)	
ePA number Obtained: ○ No ○ Yes ePA Number:	Expiration Date:

Justification for this non-formulary medication. Include what formulary medications have been tried and the outcome

- ☑ Renewal of previously approved non-formulary medication Explain: _____
- ☐ Patient is allergic/intolerant to medication on formulary Explain: _____
- ☐ Formulary medication has been tried and is ineffective - List: Explain: _____
- ☐ Patient has significant medical problem unresponsive to formulary medication Explain:
- ☐ No comparable medication on formulary Explain:

Renewal of subsequent order compliance (Determined by Review of MAR): ○ >80% ○ <80%

Practitioner Information: ○ Physician ◉ NP (PA) ○ Dentist ○ Psychiatrist

Name: _____ Signature _____

Daytime Phone: _____ Pager/Cell Number: _____

Date: _____

Site Medical Director	**Regional Medical Director**
☐ Approved as Requested	☑ Approved as Requested
☐ Approved with Modifications	☐ Approved with Modifications
☐ Alternative Treatment Recommended	☐ Alternative Treatment Recommended
Explanation/Recommendation:	**Explanation/Recommendation:**
Print Name: _____	**Print Name:** _____
Signature: _____	**Signature:** Rebekah Haggard
Date: _____	**Date:** 2/17/17

CS2607

CORIZON HEALTH

NF

Non-Formulary **Pharmacy** Request Forms

Form must be complete and legible. **You must Type or Print.**

Site Name and Number: ISCI 6340	Site Phone #: 2083360740	Site Fax #: 2083380085	
Patient Name (Last, First): Edmo, M	Date of Birth: [redacted]	Sex: ● Male ○ Female	
ID #: 94691	Date of Incarceration:	Expected Date of Release:	
Diagnosis: GD			
Medication Allergies: NKDA			
Requested Non-Formulary Medication and Strength: Estrace 3mg SL BID			
Directions: may use oral tab off label as SL per specialist			

Duration of Therapy: (Maximum duration: Jails 90 days; Prisons 90 days) ○ 7 days ○ 10 days ○ 14 days ○ 21 days ○ 30 days ◉ 90 days ○ Other: _____ days ☐ Profile only (medication will not be sent)

ePA number Obtained: ○ No ○ Yes ePA Number: Expiration Date:

Justification for this non-formulary medication. Include what formulary medications have been tried and the outcome

- ☒ Renewal of previously approved non-formulary medication Explain:
- ☐ Patient is allergic/intolerant to medication on formulary Explain:
- ☐ Formulary medication has been tried and is ineffective - List: Explain:
- ☐ Patient has significant medical problem unresponsive to formulary medication Explain:
- ☐ No comparable medication on formulary Explain:

Renewal of subsequent order compliance (Determined by Review of MAR): ○ > 80% ○ < 80%

Practitioner Information: ○ Physician ○ NP / PA ○ Dentist ○ Psychiatrist

Name: MValley PA-C **Signature** MV

Daytime Phone: _____ **Pager/Cell Number:** _____

Date: 2/14/17

Site Medical Director	**Regional Medical Director**
☐ Approved as Requested	☐ Approved as Requested
☐ Approved with Modifications	☐ Approved with Modifications
☐ Alternative Treatment Recommended	☐ Alternative Treatment Recommended
Explanation/Recommendation:	**Explanation/Recommendation:**
Print Name:	**Print Name:**
Signature:	**Signature:**
Date:	**Date:**

CS2607

CORIZON HEALTH

NF

Non-Formulary **Pharmacy** Request Forms

Form must be complete and legible. **You must Type or Print.**

Site Name and Number: ISCI 6340	Site Phone #: 2083360740	Site Fax #: 208 338 0085	
Patient Name (Last, First): Edmo, Mason	Date of Birth: [redacted]	Sex: ● Male	○ Female
ID #: 94691	Date of Incarceration:	Expected Date of Release:	
Diagnosis:			
Medication Allergies:			
Requested Non-Formulary Medication and Strength: Estradiol 3mg BID Sublingually			
Directions:			

Duration of Therapy: (Maximum duration: Jails 90 days; Prisons 90 days) ○ 7 days ○ 10 days ○ 14 days ○ 21 days ○ 30 days ○ 90 days ○ Other: _____ days ☐ Profile only (medication will not be sent)

ePA number Obtained: ○ No ○ Yes ePA Number: Expiration Date:

Justification for this non-formulary medication. Include what formulary medications have been tried and the outcome

- ☒ Renewal of previously approved non-formulary medication Explain: _____
- ☐ Patient is allergic/intolerant to medication on formulary Explain: _____
- ☐ Formulary medication has been tried and is ineffective - List: Explain: _____
- ☐ Patient has significant medical problem unresponsive to formulary medication Explain:
- ☐ No comparable medication on formulary Explain:

Renewal of subsequent order compliance (Determined by Review of MAR): ○ > 80% ○ < 80%

Practitioner Information: ○ Physician ● NP / PA ○ Dentist ○ Psychiatrist

Name: Anthony Bushnell, PA-C **Signature** [signature]

Daytime Phone: _____ **Pager/Cell Number:** _____

Date: _____

Site Medical Director	**Regional Medical Director**
☐ Approved as Requested	☐ Approved as Requested
☐ Approved with Modifications	☐ Approved with Modifications
☐ Alternative Treatment Recommended	☐ Alternative Treatment Recommended
Explanation/Recommendation:	**Explanation/Recommendation:**
Print Name: _____	**Print Name:** _____
Signature: _____	**Signature:** _____
Date: _____	**Date:** _____

CS2607

Idaho Medication Non Adherence
(Missed three consecutive doses or a pattern of non adherence)
Notification to Prescribing Practitioner

Patient Name	Edmo Mason	Patient ID#	94691
Prescribing Practitioner	Poulson		
Reported By	MGonzalez LPN	Date of Report	12/4/14

Medication Order ELAVIL	
Non Compliance Issue ☒ Missed 3 consecutive doses ☐ Pattern of non adherence	Describe ÷ tab 10mg PO q HS x 90days

Medication Order	
Non Compliance Issue ☒ Missed 3 consecutive doses ☐ Pattern of non adherence	Describe Absent for P.M Pass

Medication Order	
Non Compliance Issue ☐ Missed 3 consecutive doses ☐ Pattern of non adherence	Describe

Nurse reporting non adherence

1. Complete this form with required information
2. Use only one form for each prescribing practitioner
3. Document completion of form on back of the MAR
4. Place mental health non adherence forms in the mail box of the mental health professional
5. *Place physical health non adherence forms in the mail box of the prescribing practitioner*

ACTION TAKEN BY PRESCRIBING PRACTITIONER

(To be completed by prescribing practitioner after review)

- ☐ No action indicated at this time
- ☐ Patient scheduled for an appointment for counseling
- ☐ Medication adjustments indicated and ordered

Additional Documentation

Prescribing Practitioner Signature	Date

Original to Medical File, Copy to Pharmacy Notebook

Idaho Medication Non Adherence
(Missed three consecutive doses or a pattern of non adherence)
Notification to Prescribing Practitioner

Patient Name	Edno, Mason	Patient ID#	94691
Prescribing Practitioner	Eliason		
Reported By	L Hill	Date of Report	1-17-14

Medication Order	Zoloft	
Non Compliance Issue ☒ Missed 3 consecutive doses ☐ Pattern of non adherence		Describe Has missed the last 3 AM pill passes

Medication Order	
Non Compliance Issue ☐ Missed 3 consecutive doses ☐ Pattern of non adherence	Describe

Medication Order	
Non Compliance Issue ☐ Missed 3 consecutive doses ☐ Pattern of non adherence	Describe

Nurse reporting non adherence

1. Complete this form with required information
2. Use only one form for each prescribing practitioner
3. Document completion of form on back of the MAR
4. Place mental health non adherence forms in the mail box of the mental health professional
5. Place physical health non adherence forms in the mail box of the prescribing practitioner

ACTION TAKEN BY PRESCRIBING PRACTITIONER
(To be completed by prescribing practitioner after review)

☒ No action indicated at this time
☐ Patient scheduled for an appointment for counseling
☐ Medication adjustments indicated and ordered

Additional Documentation

Prescribing Practitioner Signature	Date
Scott Eliason, MD	1/21/15

Original to Medical File, Copy to Pharmacy Notebook

Idaho Medication Non Adherence
(Missed three consecutive doses or a pattern of non adherence)
Notification to Prescribing Practitioner

Patient Name	Edmo, Mason	Patient ID#	49691
Prescribing Practitioner	Eliason		
Reported By	LHill	Date of Report	1-24-15

Medication Order Zoloft	
Non Compliance Issue ☒ Missed 3 consecutive doses ☐ Pattern of non adherence	Describe Has missed the last 3 AM pill pass

Medication Order	
Non Compliance Issue ☐ Missed 3 consecutive doses ☐ Pattern of non adherence	Describe

Medication Order	
Non Compliance Issue ☐ Missed 3 consecutive doses ☐ Pattern of non adherence	Describe

Nurse reporting non adherence

1. Complete this form with required information
2. Use only one form for each prescribing practitioner
3. Document completion of form on back of the MAR
4. Place mental health non adherence forms in the mail box of the mental health professional
5. Place physical health non adherence forms in the mail box of the prescribing practitioner

ACTION TAKEN BY PRESCRIBING PRACTITIONER
(To be completed by prescribing practitioner after review)

☐ No action indicated at this time
☐ Patient scheduled for an appointment for counseling
☐ Medication adjustments indicated and ordered

SCH 1/28

Additional Documentation
See notes 1/28/15

Prescribing Practitioner Signature	Date

Original to Medical File, Copy to Pharmacy Notebook

Idaho Medication Non Adherence

(Missed three consecutive doses or a pattern of non adherence)

Notification to Prescribing Practitioner

Patient Name	Edmo, Mason	Patient ID#	94691
Prescribing Practitioner	Gelok		
Reported By	Tasha	Date of Report	2/13/15

Medication Order Fluoxetine	
Non Compliance Issue ☑ Missed 3 consecutive doses ☐ Pattern of non adherence	Describe refusing

Medication Order	
Non Compliance Issue ☐ Missed 3 consecutive doses ☐ Pattern of non adherence	Describe

Medication Order	
Non Compliance Issue ☐ Missed 3 consecutive doses ☐ Pattern of non adherence	Describe

Nurse reporting non adherence

1. **Complete this form with required information**
2. **Use only one form for each prescribing practitioner**
3. **Document completion of form on back of the MAR**
4. **Place mental health non adherence forms in the mail box of the mental health professional**
5. **Place physical health non adherence forms in the mail box of the prescribing practitioner**

ACTION TAKEN BY PRESCRIBING PRACTITIONER

(To be completed by prescribing practitioner after review)

- ☐ **No action indicated at this time**
- ☐ **Patient scheduled for an appointment for counseling**
- ☑ **Medication adjustments indicated and ordered**

Additional Documentation

Prescribing Practitioner Signature	Christian Gelok, NP FEB 19 2015	**Date**

Original to Medical File, Copy to Pharmacy Notebook

Idaho Medication Non Adherence

(Missed three consecutive doses or a pattern of non adherence)

Notification to Prescribing Practitioner

Patient Name	Edme, Mason	Patient ID#	94691
Prescribing Practitioner	Eliason		
Reported By	Shauna Kelly RMA	Date of Report	3/6/15

Medication Order	Sertraline HCL 50mg	
Non Compliance Issue ☒ Missed 3 consecutive doses ☒ Pattern of non adherence	Absent	Describe Zoloft 50mg tabs - Take 3 tabs PO QHS x 120 days

Medication Order		
Non Compliance Issue ☐ Missed 3 consecutive doses ☐ Pattern of non adherence		Describe

Medication Order		
Non Compliance Issue ☐ Missed 3 consecutive doses ☐ Pattern of non adherence		Describe

Nurse reporting non adherence

1. **Complete this form with required information**
2. **Use only one form for each prescribing practitioner**
3. **Document completion of form on back of the MAR**
4. **Place mental health non adherence forms in the mail box of the mental health professional**
5. **Place physical health non adherence forms in the mail box of the prescribing practitioner**

ACTION TAKEN BY PRESCRIBING PRACTITIONER

(To be completed by prescribing practitioner after review)

☐ **No action indicated at this time**
☒ **Patient scheduled for an appointment for counseling**
☐ **Medication adjustments indicated and ordered**

Additional Documentation

Prescribing Practitioner Signature	Jeremy Stoddart, MD	**Date**
		3/10/15

Original to Medical File, Copy to Pharmacy Notebook

Idaho Medication Non Adherence

(Missed three consecutive doses or a pattern of non adherence)

Notification to Prescribing Practitioner

Patient Name	Edmo, Mason	Patient ID#	94691
Prescribing Practitioner	Gleason		
Reported By	Amber Huddleston	Date of Report	3/9/15

Medication Order Zoloft 50mg	
Non Compliance Issue ☒ Missed 3 consecutive doses ☒ Pattern of non adherence	Describe Zoloft 50mg QAMs & PMs

Medication Order	
Non Compliance Issue ☐ Missed 3 consecutive doses ☐ Pattern of non adherence	Describe

Medication Order	
Non Compliance Issue ☐ Missed 3 consecutive doses ☐ Pattern of non adherence	Describe

Nurse reporting non adherence

1. **Complete this form with required information**
2. **Use only one form for each prescribing practitioner**
3. **Document completion of form on back of the MAR**
4. **Place mental health non adherence forms in the mail box of the mental health professional**
5. **Place physical health non adherence forms in the mail box of the prescribing practitioner**

ACTION TAKEN BY PRESCRIBING PRACTITIONER

(To be completed by prescribing practitioner after review)

☐ **No action indicated at this time**
☒ **Patient scheduled for an appointment for counseling**
☐ **Medication adjustments indicated and ordered**

Additional Documentation

Prescribing Practitioner Signature	**Date**
Jeremy Stoddart, MD	3/10/15

Original to Medical File, Copy to Pharmacy Notebook

Idaho Medication Non Adherence

(Missed three consecutive doses or a pattern of non adherence)

Notification to Prescribing Practitioner

Patient Name	Edson, MASON	Patient ID#	94691
Prescribing Practitioner	Eliason		
Reported By	Sheela Pemberton RN	Date of Report	

Medication Order	SERTRALINE 50mg – 3 TABS PO @ Bedtime x 120 days	
Non Compliance Issue		Describe
☒ Missed 3 consecutive doses		Absent 1, 2, 3
☐ Pattern of non adherence		

Medication Order	
Non Compliance Issue	Describe
☐ Missed 3 consecutive doses	
☐ Pattern of non adherence	

Medication Order	
Non Compliance Issue	Describe
☐ Missed 3 consecutive doses	
☐ Pattern of non adherence	

Nurse reporting non adherence

1. **Complete this form with required information**
2. **Use only one form for each prescribing practitioner**
3. **Document completion of form on back of the MAR**
4. **Place mental health non adherence forms in the mail box of the mental health professional**
5. **Place physical health non adherence forms in the mail box of the prescribing practitioner**

ACTION TAKEN BY PRESCRIBING PRACTITIONER

(To be completed by prescribing practitioner after review)

- ☐ **No action indicated at this time**
- ☒ **Patient scheduled for an appointment for counseling**
- ☐ **Medication adjustments indicated and ordered**

Additional Documentation

Prescribing Practitioner Signature	Jeremy Stoddart, MD	**Date** 3/10/15

Original to Medical File, Copy to Pharmacy Notebook

.Jaho Medication Non Adherence

(Missed three consecutive doses or a pattern on non adherence Notification to Prescribing Practitioner)

Patient Name	Eddins, Mason	IDOC #	94691
Prescribing Practitioner	Eliason		
Reported By	[illegible]	Date of Report	2/13/16

Medication Order: Remeron 7.5mg QHS	
Non Compliance Issue: ☒ Missed 3 consecutive doses ☒ Pattern of non adherence	Describe: absent for 13 days QHS

Medication Order:	
Non Compliance Issue: ☐ Missed 3 consecutive doses ☐ Pattern of non adherence	Describe:

Medication Order:	
Non Compliance Issue: ☐ Missed 3 consecutive doses ☐ Pattern of non adherence	Describe:

Nurse reporting non adherence

1. **Complete this form with required information**
2. **Use only one form for each prescribing practitioner**
3. **Document completion of form of back of MAR**
4. **Place mental health non adherence forms in the mail box of the mental health professional**
5. **Place physical health non adherence forms in the mail box of the prescribing practitioner**

Received in Mental Health
DATE: 2/15

last seen 1/27
scheduled 4/20 Dr Eliason

ACTION TAKEN BY PRESCRIBING PRACTITIONER

(To be completed by prescribing practitioner after review)

- ☐ **No action indicated at this time**
- ☐ **Patient scheduled for an appointment for counseling**
- ☒ **Medication adjustments indicated and ordered**

Additional Documentation D/C Remeron

Prescribing Practitioner Signature [signature] **Date** 2/17/16

Original to Medical File, Copy to Pharmacy Notebook

Idaho Medication Non Adherence
(Missed three consecutive doses or a pattern of non adherence)
Notification to Prescribing Practitioner

Patient Name	Edmo, mason	Patient ID#	94691
Prescribing Practitioner	Pawson		
Reported By	Elizabeth Jarvis	Date of Report	11.22.16

Medication Order	Calcium Carb 1250 mg / Vit D 1250 mg
Non Compliance Issue ☒ Missed 3 consecutive doses ☐ Pattern of non adherence	Describe Absent for med on 20, 21, 22

Medication Order	
Non Compliance Issue ☐ Missed 3 consecutive doses ☐ Pattern of non adherence	Describe

Medication Order	
Non Compliance Issue ☐ Missed 3 consecutive doses ☐ Pattern of non adherence	Describe

Nurse reporting non adherence

1. Complete this form with required information
2. Use only one form for each prescribing practitioner
3. Document completion of form on back of the MAR
4. Place mental health non adherence forms in the mail box of the mental health professional
5. Place physical health non adherence forms in the mail box of the prescribing practitioner

ACTION TAKEN BY PRESCRIBING PRACTITIONER
(To be completed by prescribing practitioner after review)

☑ No action indicated at this time
☐ Patient scheduled for an appointment for counseling
☐ Medication adjustments indicated and ordered

Additional Documentation

Prescribing Practitioner Signature	Date
[signature]	Anthony Bushnell, PA-C 13/8 NOV 25 2016

Original to Medical File, Copy to Pharmacy Notebook

CP7798ID-Idaho– Medication Non Adherence – created 6/2011

Idaho Medication Non Adherence

(Missed three consecutive doses or a pattern of non adherence)
Notification to Prescribing Practitioner

Patient Name	Edmo, mason	Patient ID#	94691
Prescribing Practitioner	Agler		
Reported By	Elizabeth Jarvis	Date of Report	11·22·16

Medication Order	Spironolactone 100 mg	
Non Compliance Issue		Describe
☒ Missed 3 consecutive doses		Absent For Pm Dose on 20,21,22
☐ Pattern of non adherence		

Medication Order	Spironolactone 25 mg	
Non Compliance Issue		Describe
☒ Missed 3 consecutive doses		Absent For Pm Dose on 20,21,22
☐ Pattern of non adherence		

Medication Order	
Non Compliance Issue	Describe
☐ Missed 3 consecutive doses	
☐ Pattern of non adherence	

Nurse reporting non adherence

1. Complete this form with required information
2. Use only one form for each prescribing practitioner
3. Document completion of form on back of the MAR
4. Place mental health non adherence forms in the mail box of the mental health professional
5. Place physical health non adherence forms in the mail box of the prescribing practitioner

ACTION TAKEN BY PRESCRIBING PRACTITIONER

(To be completed by prescribing practitioner after review)

NOV 25 2016

- ☐ No action indicated at this time
- ☒ Patient scheduled for an appointment for counseling
- ☐ Medication adjustments indicated and ordered

Additional Documentation
counsel & Nursy

Prescribing Practitioner Signature	Date
[signature]	Anthony Bushnell, PA-C 1318 NOV 25 2016

Original to Medical File, Copy to Pharmacy Notebook

Idaho Medication Non Adherence
(Missed three consecutive doses or a pattern of non adherence)
Notification to Prescribing Practitioner

Patient Name	Edmo	Patient ID#	94691
Prescribing Practitioner	Seys		
Reported By	Lyndsey	Date of Report	2-3-17

Medication Order: Remeron	
Non Compliance Issue ☒ Missed 3 consecutive doses ☐ Pattern of non adherence	Describe Refused

Medication Order	
Non Compliance Issue ☐ Missed 3 consecutive doses ☐ Pattern of non adherence	Describe

Medication Order	
Non Compliance Issue ☐ Missed 3 consecutive doses ☐ Pattern of non adherence	Describe

Nurse reporting non adherence

1. Complete this form with required information
2. Use only one form for each prescribing practitioner
3. Document completion of form on back of the MAR
4. Place mental health non adherence forms in the mail box of the mental health professional
5. Place physical health non adherence forms in the mail box of the prescribing practitioner

ACTION TAKEN BY PRESCRIBING PRACTITIONER
(To be completed by prescribing practitioner after review)

☒ No action indicated at this time
☐ Patient scheduled for an appointment for counseling
☐ Medication adjustments indicated and ordered

Additional Documentation: DR. Stoddart's pt.
~~DTE~~ Did he miss in January?

Prescribing Practitioner Signature	Jane Seys PNP	Date
Jane Seys		2/9/17

Original to Medical File, Copy to Pharmacy Notebook

Idaho Medication Non Adherence
(Missed three consecutive doses or a pattern of non adherence)
Notification to Prescribing Practitioner

Patient Name	Edmo, Mason	Patient ID#	94691
Prescribing Practitioner	Seg		
Reported By	Sheila Perrin LPN	Date of Report	2-13-17

Medication Order Remeron 15mg PO Q HS x 120 days	
Non Compliance Issue ☒ Missed 3 consecutive doses ☐ Pattern of non adherence	Describe Refused 2/11 2/12 2/13

Medication Order	
Non Compliance Issue ☐ Missed 3 consecutive doses ☐ Pattern of non adherence	Describe

Medication Order	
Non Compliance Issue ☐ Missed 3 consecutive doses ☐ Pattern of non adherence	Describe

Nurse reporting non adherence

1. **Complete this form with required information**
2. **Use only one form for each prescribing practitioner**
3. **Document completion of form on back of the MAR**
4. **Place mental health non adherence forms in the mail box of the mental health professional**
5. **Place physical health non adherence forms in the mail box of the prescribing practitioner**

ACTION TAKEN BY PRESCRIBING PRACTITIONER
(To be completed by prescribing practitioner after review)

☐ **No action indicated at this time**
☐ **Patient scheduled for an appointment for counseling**
☒ **Medication adjustments indicated and ordered**

Additional Documentation

Prescribing Practitioner Signature [signature]	**Date** 2/14/17

Original to Medical File, Copy to Pharmacy Notebook

CP7798ID-Idaho– Medication Non Adherence – created 6/2011

CORRECTIONAL MEDICAL SERVICES
CCHC INTRASYSTEM TRANSFER FO

Transferring Facility ISCI/RDU

Name Meeks, Mason ID# 94691 DOB [redacted]

Current Acute Problems: No Yes (List) _____

Chronic Clinics/Problems: No Yes (List) _____

Allergies: No Yes (List) _____

Medication Name & Dose	Frequency and duration	Last time taken	# of pills sent
Ø			

Current Treatments: No Yes (List) _____

Consults Scheduled: No Yes (List) _____

Follow-up Care Needed (include lab, x-ray, & other pending appointments) No Yes (List) _____

Last TB screening: Date: 1/4/10 Result: Neg

Physical Disabilities: No Yes (List) _____

Devices/Prosthetics: No Yes (List) _____

Currently treated by Mental Health No Yes

Hx Suicide Attempt: No Yes Date _____ Hx Previous Psychiatric Hospitalizations: No Yes

Substance abuse: No Yes Alcohol: No Yes Drugs: No Yes

Hx Psychotropic Medication: No Yes *(current medications listed above)*

Prepared by: _____ 2/4/10 2100

Signature and Title Date Time

****

RECEIVING SCREENING

Receiving Facility NICI

☑ Transfer form & medical record reviewed for current medications, treatments, pending consults, and required follow up for medical/dental care.

☐ Transfer form & medical record reviewed for psychotropic medications, mental health conditions, suicidal history, and required follow up for mental health care.

Disposition: (Instructions - Check or circle as appropriate)

____ Arrangements made for medication administration
____ Arrangements made for physician review or scheduling of pending consults
____ Arrangements made to continue current treatments
✓ Routine Sick Call
____ Emergency Referral
____ Physician Referral
Urgent / Routine
____ Mental Health
Urgent / Routine
____ Infirmary Placement
____ OTHER _____

T 99.4 P 79 R 16 BP 120/70 O2 96%

Comments: _____

Receiving Nurse's Signature: _____ Date 2-8-10 Time 1500

7190 NCCHC Rev 03/04

CMS Correctional Medical Services

CORRECTIONAL MEDICAL SERVICES
NCCHC INTRASYSTEM TRANSFER FORM

Transferring Facility ISIC
Name EDMO ID# 94691 DOB [redacted]
Current Acute Problems: ☒ No ☐ Yes (List)
Chronic Clinics/Problems: ☒ No ☐ Yes (List)
Allergies: ☒ No ☐ Yes (List) NKDA

Medication Name & Dose	Frequency and duration	Last time taken	# of pills sent
Paraf for Forte	500mg ½ P.O. BID X90days		
Neurontin 600	600mg ½ P.O. TID X180days		

Current Treatments: ☒ No ☐ Yes (List)
Consults Scheduled: ☒ No ☐ Yes (List)
Follow-up Care Needed (include lab, x-ray, & other pending appointments): ☒ No ☐ Yes (List) OPC
Last TB screening: Date 5/5/12 Result: 0mm
Physical Disabilities: ☒ No ☐ Yes (List)
Devices/Prosthetics: ☒ No ☐ Yes (List)
Currently treated by Mental Health ☒ No ☐ Yes
Hx Suicide Attempt: ☐ No ☒ Yes Date 6/2011 Hx Previous Psychiatric Hospitalizations: ☐ No ☐ Yes
Substance abuse: ☐ No ☒ Yes Alcohol: ☐ No ☒ Yes Drugs: ☐ No ☒ Yes
Hx Psychotropic Medication: ☐ No ☒ Yes *(current medications listed above)*
Prepared by: E Joshua RN 6-3-12 1145
Signature and Title Date Time

RECEIVING SCREENING

Receiving Facility ISCI
☒ Transfer form & medical record reviewed for current medications, treatments, pending consults, and required follow up for medical/dental care.
☐ Transfer form & medical record reviewed for psychotropic medications, mental health conditions, suicidal history, and required follow up for mental health care.
Receiving Nurse's Signature: Sharon Patterson, LPN Date: 6-5-12 Time: 0200

Required follow up for mental health care.
Disposition: (Instructions – Check as appropriate)

☐ Arrangements made for medication administration	☐ Physician Referral ☐ Urgent ☐ Routine
☐ Arrangements made to continue current treatments	☐ Mental Health ☐ Urgent ☐ Routine
☐ Routine Sick Call	☐ Infirmary Placement
☐ Emergency Referral	☒ OTHER
Comments: OPC	

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CMS Correctional Medical Services

CORRECTIONAL MEDICAL SERVICES
NCCHC INTRASYSTEM TRANSFER FORM

Transferring Facility ISCI

Name Elms, Mason ID# 94691 DOB [redacted]

Current Acute Problems: [X] No [ ] Yes (List)

Chronic Clinics/Problems: [ ] No [X] Yes (List) Hx HTN, Ø Meds

Allergies: [X] No [ ] Yes (List)

Medication Name & Dose	Frequency and duration	Last time taken	# of pills sent
Toldt 150 mg	po QHS x 120 days	7/16/12	66
Paraflon Forte 500 mg	po BID x 90 days	7/16/12	57
Neurontin 600mg	po TID x 180 days	7/16/12	44

Current Treatments: [X] No [ ] Yes (List)

Consults Scheduled: [X] No [ ] Yes (List)

Follow-up Care Needed (include lab, x-ray, & other pending appointments) [ ] No [X] Yes (List) Mental Health 8/15/12

Last TB screening: Date ~~4/24/11~~ 5/5/12 Result: 0 mm

Physical Disabilities: [X] No [ ] Yes (List)

Devices/Prosthetics: [X] No [ ] Yes (List)

Currently treated by Mental Health [ ] No [X] Yes

Hx Suicide Attempt: [ ] No [X] Yes Date 6/2011 Hx Previous Psychiatric Hospitalizations: [ ] No [X] Yes

Substance abuse: [ ] No [X] Yes Alcohol: [ ] No [X] Yes Drugs: [X] No [ ] Yes

Hx Psychotropic Medication: [ ] No [X] Yes *(current medications listed above)*

Prepared by:

Jaimie Maxey, LPN 7/16/12 2330

Signature and Title Date Time

RECEIVING SCREENING

Receiving Facility IMSI

[X] Transfer form & medical record reviewed for current medications, treatments, pending consults, and required follow up for medical/dental care.

[X] Transfer form & medical record reviewed for psychotropic medications, mental health conditions, suicidal history, and required follow up for mental health care.

Receiving Nurse's Signature: B Fackrell RN Becky Fackrell, R.N. Date: 7-17-12 Time: 1600

Required follow up for mental health care. Disposition: (Instructions – Check as appropriate)	
[X] Arrangements made for medication administration	[ ] Physician Referral [ ] Urgent [ ] Routine
[X] Arrangements made to continue current treatments	[ ] Mental Health [ ] Urgent [ ] Routine
[ ] Routine Sick Call	[ ] Infirmary Placement
[ ] Emergency Referral	[ ] OTHER
Comments:	

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CP7190N-ID NCCHC Intrasystem Transfer Form – Created 2004 Last Reviewed 2010 (E03.00b)

CMS Correctional Medical Services

CORRECTIONAL MEDICAL SERVICES
NCCHC INTRASYSTEM TRANSFER FORM

Transferring Facility: ISI

Name: EAMO ID#: 941691 DOB: [redacted]

Current Acute Problems: ☑ No ☐ Yes (List)

Chronic Clinics/Problems: ☑ No ☐ Yes (List) NO Chronic Care documentation avail.

Allergies: ☑ No ☐ Yes (List)

Medication Name & Dose	Frequency and duration	Last time taken	# of pills sent
Zoloft 150mg	PO HS X 120 days	7-25-12	47
Parafon Forte 500mg	PO BID X 90 days	7-26-12	34
Neurontin 600mg	PO TID X 90	7-26-12	41

Current Treatments: ☑ No ☐ Yes (List) Hx of HTC w/o meds

Consults Scheduled: ☑ No ☐ Yes (List)

Follow-up Care Needed (include lab, x-ray, & other pending appointments) ☐ No ☑ Yes (List) with mental health

Last TB screening: Date 5/5/12 Result: 0 mm.

Physical Disabilities: ☑ No ☐ Yes (List)

Devices/Prosthetics: ☑ No ☐ Yes (List)

Currently treated by Mental Health ☐ No ☑ Yes

Hx Suicide Attempt: ☐ No ☑ Yes Date 6/2011 Hx Previous Psychiatric Hospitalizations: ☐ No ☑ Yes

Substance abuse: ☐ No ☑ Yes Alcohol: ☐ No ☑ Yes Drugs: ☐ No ☐ Yes

Hx Psychotropic Medication: ☐ No ☑ Yes *(current medications listed above)*

Prepared by:

Vickie Griggs CPhT RMA — Vickie Griggs, RMA, CPh.T.
Signature and Title

July 26, 2012
Date

0850
Time

RECEIVING SCREENING

Receiving Facility: ISCI

☑ Transfer form & medical record reviewed for current medications, treatments, pending consults, and required follow up for medical/dental care.

☑ Transfer form & medical record reviewed for psychotropic medications, mental health conditions, sulcidal history, and required follow up for mental health care.

Receiving Nurse's Signature: Joe Smith, LPN Date: 7/27/12 Time: 0715

Required follow up for mental health care.

Disposition: (Instructions – Check as appropriate)

☑ Arrangements made for medication administration	☐ Physician Referral ☐ Urgent ☐ Routine
☐ Arrangements made to continue current treatments	☑ Mental Health ☐ Urgent ☑ Routine
☑ Routine Sick Call	☐ Infirmary Placement
☐ Emergency Referral	☐ OTHER
Comments:	

Original – patient chart Copy – for IDOC audit

CMS Correctional

CORRECTIONAL MEDICAL SERVICES
NCCHC INTRASYSTEM TRANSFER FORM

Transferring Facility ISCI

Name Edmo, Mason ID# 94691 DOB [redacted]

Current Acute Problems: ☐ No ☐ Yes (List) see HSR #589255

Chronic Clinics/Problems: ☐ No ☒ Yes (List) GID MH Hx HTN Ømeds

Allergies: ☒ No ☐ Yes (List)

Medication Name & Dose	Frequency and duration	Last time taken	# of pills sent
Proscar 5	d1 x 90 D		14
Proscar 5	d1 x 90 D to start 8/29/13		
Prozac 30	q am x 120 D		57
Paragon Forte 500	1 tab TID PRN x 30D		30
EC ASA 81	d1 x 180 D		29
Oscal-D 500	d1 x 180 D		26
Estrace 2	d1 x 90 D		40
Estrace 2	d1 x 90 D to start 8/29/13		

Current Treatments: ☐ No ☒ Yes (List) MH CC

Consults Scheduled: ☒ No ☐ Yes (List)

Follow-up Care Needed (include lab, x-ray, & other pending appointments) ☐ No ☒ Yes (List) sch for CC f/u re: HSR #589255 MH f/u 9/18/13 (CC f/u 9/29 c̄ RN 11/29 c̄ MD)

Last TB screening: Date 10/18/12 Result: Ømm

Physical Disabilities: ☒ No ☐ Yes (List)

Devices/Prosthetics: ☐ No ☒ Yes (List) glasses, bra

Currently treated by Mental Health ☐ No ☐ Yes

Hx Suicide Attempt: ☐ No ☒ Yes Date 6/15/12 Hx Previous Psychiatric Hospitalizations: ☐ No ☒ Yes

Substance abuse: ☐ No ☒ Yes Alcohol: ☐ No ☒ Yes Drugs: ☐ No ☒ Yes

Hx Psychotropic Medication: ☐ No ☒ Yes *(current medications listed above)*

Prepared by

Effie Reed, LPN

Signature and Title Date 8/12/13 Time 0030

RECEIVING SCREENING

Receiving Facility ICIO

☒ Transfer form & medical record reviewed for current medications, treatments, pending consults, and required follow up for medical/dental care.

☒ Transfer form & medical record reviewed for psychotropic medications, mental health conditions, suicidal history, and required follow up for mental health care.

Receiving Nurse's Signature: T Miller RN Date: 8/12/13 Time: 19^40

Tammy Miller, RN

Required follow up for mental health care. Disposition: (Instructions – Check as appropriate)	
☐ Arrangements made for medication administration	☒ Physician Referral ☐ Urgent ☒ Routine
☒ Arrangements made to continue current treatments	☒ Mental Health ☐ Urgent ☒ Routine
☒ Routine Sick Call	☐ Infirmary Placement
☐ Emergency Referral	☐ OTHER
Comments:	

Original – patient chart Copy – for IDOC audit

CP7190N-ID NCCHC Intrasystem Transfer Form – Created 2004 Last Reviewed 2010 (E03.00b)

CORIZON
Promote a culture of safety

Intra-System Transfer Form

Transfer Facility: ICI-O

Patient Name: Edmo Masan ID#: 94691 DOB: [redacted]

Current Acute Problems: ~~No~~ Yes: refer to GID evaluator

Current Clinics / Problems: No Yes:

Med Allergies: ~~NKDA~~ List:

Medication Name & Dose	Frequency & Duration	Last Time	Number of Pills Sent
ASA 81mg	QD x 120 days	2/19/14 AM	22
oscal 1200mg/1250mg	QD x 120 days	2/19/14 AM	54
zoloft 150mg	QD x 120 days	2/19/14 AM	9
aldactone 50mg	BID x 120 days	2/19/14 AM	13
estrace 2mg	QD x 120 days	2/19/14 AM	24
proscar 5mg	QD x 120 days	2/19/14 AM	10

Recent Surgery/Hospitalizations: ~~No~~ Yes:

Current Treatments: ~~No~~ Yes:

Consults Scheduled: ~~No~~ Yes

Follow-up Care Needed (include lab, x-ray & other pending appointments): ~~No~~ Yes:

Last TB Screening: Date: 10/27/13 Result: Ø mm Last Physical: 4/30/12

Devices / Prosthetics: ~~No~~ Yes:

Currently Treated By Mental Health: No ~~Yes~~: GID

Hx Suicide Attempt: No ~~Yes~~ Date: 2010 Hx Previous Psychiatric Hospitalizations: No ~~Yes~~

Substance Abuse: No ~~Yes~~ Alcohol: No ~~Yes~~ Drugs: No ~~Yes~~

Hx Psychotropic Medications: ~~No~~ Yes (current medications listed above)

PREPARED BY

Signature	Title	Printed/Stamped	Date/Time
Brown	RN	Sharon Brown, RN	2/18/14 1950

RECEIVING SCREENING

Receiving Facility:

☑ Transfer form & medical record reviewed for current medications, treatments, pending consults, and required follow up for medical/dental care

☑ Transfer form & medical record reviewed for psychotropic medications, mental health conditions, suicidal history, and required follow up for mental health care.

Current Medical, Mental Health or Dental Complaint (including suicidal ideations): ~~No~~ Yes:

Physical Appearance/Behavior: Signs of Abuse/Trauma: ~~No~~ Yes

Deformities: Acute/Chronic ~~No~~ Yes:

Vital Signs: T: P: R: BP: /

Inmate Transfer Review

Disposition (Check all that apply):
☐ Arrangements made for physician review or scheduling of pending consults
☑ Arrangements made for medication administration ☐ Arrangements made to continue current treatments
☑ Routine Sick Call ☐ Physician Referral ☐ Urgent ☐ Routine ☐ Mental Health ☐ Urgent ☐ Routine
☐ Infirmary Placement ☐ Other:

RECEIVING

Signature	Title	Printed/Stamped	Date/Time
Rachael Malone	RP	Rachael Malone, LPN	2-19-14 1330

CS2000

CMS Correctional Medical

RECEIPT FOR MEDICAL PRODUCT

(Recibo de Productos Medicos)

Inmate Name (Preso nombre): 94691

ID# (Número de identificación): EOMO

Institution (Institución): ISCI

Housing Unit (Unidades de Vivienda): 16

Medical Product (Productos Médicos): Glasses

Date Received (Fecha de recepción): 12 Feb 13

I verify that I have received the medical product named above. I understand I am fully responsible for the care of this item. I further understand that I may be required to pay for any repair or replacement.
(Yo certifico que he recibido el producto médicas indicadas anteriormente. Entiendo que soy plenamente responsable del cuidado de este artículo. Además, entiendo que puedo ser obligado a pagar por cualquier reparación o reemplazo.)

Inmate Signature (Preso Firma)

Signature of Health Care Staff Dispensing Product
(Firma del personal de salud de Atención para la distribución de productos)

CMS
DEDICATED PEOPLE MAKING A DIFFERENCE
Correctional Medical Services

RECEIPT FOR DENTAL PRODUCT

Offender Name: Edmo ID#: 94691

Institution: ICI-O Date Received: 9/4/13

Dental Product: upper dentures / lower Partial

I verify that I have received the dental product named above. I understand I am fully responsible for the care of this item. I further understand that I.D.O.C. will only allow the replacement of this product every five years.

Offender Signature

Signature of Healthcare Staff Dispensing Product

CMS Correctional Medical Services

RECEIPT FOR MEDICAL PRODUCT

(Recibo de Productos Medicos)

Inmate Name (Preso nombre): Edmo

ID# (Número de identificación): 94691

Institution (Institución): ISCI

Housing Unit (Unidades de Vivienda): _____

Medical Product (Productos Médicos): Glasses

Date Received (Fecha de recepción): 8/19/14

I verify that I have received the medical product named above. I understand I am fully responsible for the care of this item. I further understand that I may be required to pay for any repair or replacement.
(Yo certifico que he recibido el producto médicas indicadas anteriormente. Entiendo que soy plenamente responsable del cuidado de este artículo. Además, entiendo que puedo ser obligado a pagar por cualquier reparación o reemplazo.)

Edmo
Inmate Signature (Preso Firma)

K.Murray, RN Kim Murray, R.N.
Signature of Health Care Staff Dispensing Product
(Firma del personal de salud de Atención para la distribución de productos)

CORIZON
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RECEIPT FOR MEDICAL PRODUCT

Inmate Name: EDMO ID 94691

Institution: ISCI Housing Unit: 16

Medical Product: jock strap #20 ABD Pads Date Received: 2-13-15

I verify that I have received the medical product named above. I understand I am fully responsible for the care of this item. I further understand that I may be required to pay for any repair or replacement.

Inmate Signature

Signature of Health Care Staff Dispensing Product

CP7188ID
3/6/2014

CORIZON™
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RECEIPT FOR MEDICAL PRODUCT

Inmate Name: Mason Edmo ID 94691

Institution: ISC I Housing Unit: 09A09B

Medical Product: 1 jock strap
11"20 ABD PADS Date Received: 4-8-15

I verify that I have received the medical product named above. I understand I am fully responsible for the care of this item. I further understand that I may be required to pay for any repair or replacement.

M Edmo

Inmate Signature

LPN

Signature of Health Care Staff Dispensing Product

CP7188ID
3/6/2014

CORIZON
Promote a culture of safety

RECEIPT FOR MEDICAL PRODUCT

Inmate Name: Mason Edmo ID 94691

Institution: ISCI Housing Unit: 15A 4813

Medical Product: Eyeglasses Date Received: 5/17/15

I verify that I have received the medical product named above. I understand I am fully responsible for the care of this item. I further understand that I may be required to pay for any repair or replacement.

Inmate Signature

L.A. Nissen, LPN L.A. Nissen, LPN

Signature of Health Care Staff Dispensing Product

CP7188ID
3/6/2014

CORIZON
Promote a culture of safety

RECEIPT FOR MEDICAL PRODUCT

Inmate Name: Edmo ID 94491

Institution: ISCI Housing Unit: _____

Medical Product: Jock Supporter (M) Date Received: 9-24-15

I verify that I have received the medical product named above. I understand I am fully responsible for the care of this item. I further understand that I may be required to pay for any repair or replacement.

Edmo

Inmate Signature

RN

Signature of Health Care Staff Dispensing Product

CP7188ID
3/6/2014

CORIZON
Promote a culture of safety

RECEIPT FOR MEDICAL PRODUCT

Inmate Name: Edmo, Mason ID 94691

Institution: ISCI Housing Unit: 15

Medical Product: glasses/case Date Received: 11/8/16

I verify that I have received the medical product named above. I understand I am fully responsible for the care of this item. I further understand that I may be required to pay for any repair or replacement.

Inmate Signature

Kelly Larsen, LPN

Signature of Health Care Staff Dispensing Product

CP7188ID
3/6/2014

CORIZON
Promote a culture of safety

RECEIPT FOR MEDICAL PRODUCT

Inmate Name: Edmo ID 94691

Institution: ISCI Housing Unit: G

Medical Product: glasses/case Date Received: 5/2/17

I verify that I have received the medical product named above. I understand I am fully responsible for the care of this item. I further understand that I may be required to pay for any repair or replacement.

Edmo
Inmate Signature

K. Larsen Kelly Larsen, LPN
Signature of Health Care Staff Dispensing Product

CP7188ID
3/6/2014

CONSENT:

I, the undersigned, hereby authorize Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with my dental care, and further authorize and consent that Doctor choose and employ such assistance as he deems fit.

I also understand the use of anesthetic agents embodies a certain risk.

I have reviewed the above medical history, and there have been no changes in my medical history. I attest that the above information is accurate to the best of my knowledge.

Signature _____ Date 5-3-12

No change ☐ Signature _____ Date _____

No change ☐ Signature _____ Date _____

No change ☐ Signature _____ Date _____

No change ☐ Signature _____ Date _____

No change ☐ Signature _____ Date _____

No change ☐ Signature _____ Date _____

No change ☐ Signature _____ Date _____

No change ☐ Signature _____ Date _____

No change ☐ Signature _____ Date _____

No change ☐ Signature _____ Date _____

OP-004 (rev. 3/01)

CORRECTIONAL MEDICAL SERVICES

RELEASE OF RESPONSIBILITY

Edmo Mason 12-7-15 1512

Name of Inmate [redacted] Date/Time

94691 12-7-15

Inmate ID Number / Date of Birth

I hereby refuse to accept the following treatment/recommendations:

pt scheduled Rn COP and HSR # 784687 pt did not show to Appt. MRN sent to pt n/s 14d.

I acknowledge I have been fully informed of and understand the above treatments or recommendations and the risk(s) involved in refusing. I hereby release and agree to hold harmless Correctional Medical Services, its employees and agents from all responsibility and ill effect, which may result from this action.

Inmate Signature Date/Time

Witness

The aforementioned inmate has refused the listed medical treatment/recommendations and has refused to sign this form

Amanda Benton, RN

Amanda Benton, RN

Witness

Julie Savell, LPN

Witness

12-7-15 1512

Date/Time

CMS

CORRECTIONAL MEDICAL SERVICES
RELEASE OF RESPONSIBILITY

Edmo, Mason   6/5/14 1450
Name of Inmate.   Date/Time

94691 [redacted]
Inmate ID Number / Date of Birth

I hereby refuse to accept the following treatment/recommendations:
Pt rescheduled d/t total recall.

I acknowledge I have been fully informed of and understand the above treatments or recommendations and the risk(s) involved in refusing. I hereby release and agree to hold harmless Correctional Medical Services, its employees and agents from all responsibility and ill effect, which may result from this action.

Inmate Signature   Date/Time

Van Drake, LPN
Witness

The aforementioned inmate has refused the listed medical treatment/recommendations and has refused to sign this form.

Prudhomme, LPN
Witness

Witness
6/5/14 1450
Date/Time

CP7120 Release of Responsibility Last Reviewed 05/2010

CMS Correctional

CORRECTIONAL MEDICAL SERVICES
RELEASE OF RESPONSIBILITY

Adree Edmo — August 2nd 2014

Name of Inmate — Date/Time

94691/ [redacted]

Inmate ID Number / Date of Birth

I hereby refuse to accept the following treatment/recommendations:

Depression Medications (100mg Zoloft)

I acknowledge I have been fully informed of and understand the above treatments or recommendations and the risk(s) involved in refusing. I hereby release and agree to hold harmless Correctional Medical Services, its employees and agents from all responsibility and ill effect, which may result from this action.

Edmo — 080214 1025

Inmate Signature — Date/Time

Witness

The aforementioned inmate has refused the listed medical treatment/recommendations and has refused to sign this form.

Witness

Witness

Date/Time

CMS Correctional Medical Services

CORRECTIONAL MEDICAL SERVICES
RELEASE OF RESPONSIBILITY

Edna — 9/28/13 0830

Name of Inmate — Date/Time

94691 [redacted]

Inmate ID Number / Date of Birth

I hereby refuse to accept the following treatment/recommendations:

Refused pill call - no reason stated — in sh

I acknowledge I have been fully informed of ~~and understand~~ the above treatments or recommendations and the risk(s) involved in refusing. I hereby release and agree to hold harmless Correctional Medical Services, its employees and agents from all responsibility and ill effect, which may result from this action.

Inmate Signature — Date/Time

Witness

The aforementioned inmate has refused the listed medical treatment/recommendations and has refused to sign this form.

[signature] 1355

Witness

[signature]

Witness

9/28/13 0830

Date/Time

CONSENT FOR MENTAL HEALTH/SUBSTANCE ABUSE TREATMENT/EVALUATION

OFFENDER NAME (Last, First, MI):	IDOC #:
Edmo, Mason	94691

It is important that you understand the kinds of services you will be provided and the terms and conditions under which these services will be offered.

I, Edmo, Mason, am requesting the following from the staff of _____: (initial all that apply)

_____ Group Counseling X Secondary MH/SA Evaluation

As a condition of that treatment service, **I acknowledge, understand, and agree to the following terms:** (please initial each item)

I am aware that the practice of psychology/psychiatry/social work/counseling/group counseling treatment is not an exact science. The program staff believes that the treatment strategies employed provide a useful intervention for mental health/substance use problems. I acknowledge that no guarantee can be made concerning the outcome of any evaluation or treatment that may be provided.

I understand that evaluation and treatment will involve the discussion of personal information about my history that, at times, may be uncomfortable.

I agree to participate in the following: (please initial all that apply)

Adjustment to Prison	Grief and Loss	Living with Depression
PTSD	Release Process Group	Stress Mgmt./Relaxation
Emotional Regulation Training	Living with Co-occurring Disorder	Living with Schizophrenia
Mood Management	Living with Bipolar Disorder	Living with OCD

Limitations on Confidentiality: (please initial each item)

I understand my rights of confidentiality apply to all communications with the therapist/counselor, subject to the limitations as described below:

I understand that, while mental health/substance abuse information is confidential, there are exceptions. A therapist is required to disclose confidential information without my consent under certain circumstances that include, but are not limited to, the following:
a) if it is determined that I pose a danger to myself or others or the security of the institution;
b) if I divulge information which would cause the therapist to develop a reasonable belief that I have abused or neglected a minor, and elderly or disabled person, or a member of another protected class; or
c) if I file a suit against the therapist for malpractice.

I understand that, while every effort will be made to guard my confidentiality, because of the nature of group therapy, absolute confidentiality cannot be guaranteed.

Duration of Consent: (please initial each item)

I am aware that I may withdraw my consent at any time with appropriate written notice. However, I agree that this authorization will remain in effect for the duration of all professional mental health/substance abuse services rendered, or until such authorization is revoked by me in writing.

I agree that a photocopy of this form may be used in lieu of the original.

I acknowledge that I have received a copy of the Consent for Mental Health/Substance Use Treatment, that I have read/had the information read to me and understand the information.

I acknowledge I have received a copy of the group expectations and ground rules.

I agree to abide by group expectations and ground rules and understand disciplinary action, as outlined in the handout, may be taken for violating said rules.

X _____ OFFENDER SIGNATURE

X 12-22-14 DATE

CORIZON HEALTH

Influenza Campaign 2014-15

Facility Staff

Consent/Declination for Vaccine

94691

Corizon @ ISCI
13500 S. Pleasant Valley Rd.
Kuna, Idaho 83634

DEMOGRAPHICS

Facility:

Name: Oliver Solano

Date of Birth: [redacted]

Corizon Employee: ○ Yes ● No

Non-Corizon Employee: ● Yes ○ No

HISTORY

1. Have you had a flu shot before? ☒ Yes ○ No

If you answer yes to any of the following questions, we will not administer a flu shot

2. Have you ever had a severe allergic reaction to a flu shot or any other vaccination, including Guillian-Barre Syndrome? ○ Yes ☒ No
3. Do you have a severe egg allergy? ○ Yes ☒ No

If you answer yes to any of the following questions, we will not administer a flu shot TODAY.

4. Are you currently taking an antibiotic for infection? ○ Yes ☒ No
5. Do you feel ill today or do you have a fever? ○ Yes ☒ No

CONSENT FOR VACCINATION

I state that the above history is true and complete to the best of my knowledge. I received the Vaccine Information statement: "Influenza Vaccine Inactivated What You Need To 2014/2015" CDC form number 42 U.S.C. §300aa-26 08/19/2014 and have been given the opportunity to ask questions.

I understand the benefits and risks of influenza vaccine, and ask that the vaccine be given to me.

Signature: O Solano Date: 10/27/14

INJECTION INFORMATION

Vaccine: Manufacturer:

Lot Number: FLUARIX 3744Y 10/27/14 EXP 6/30/15 R DELT W WINGERT RN

Site: ○ Right Deltoid

on Date:

Administered By	Title	Date

Declination for Vaccination

I have received the vaccine this Influenza season from another source. ○ Yes

I decline the vaccine at this time. ○ Yes

Signature: Date:

NA0661
08/2012

Revised 8/2014

CONSENT FOR MENTAL HEALTH/SUBSTANCE ABUSE TREATMENT/EVALUATION

OFFENDER NAME (Last, First, MI):	IDOC #:
Edmo, Mason, D	94691

It is important that you understand the kinds of services you will be provided and the terms and conditions under which these services will be offered.

I, Edmo, Mason, am requesting the following from the staff of _____: (initial all that apply)

__X__ Group Counseling __X__ Secondary MH/SA Evaluation

As a condition of that treatment service, **I acknowledge, understand, and agree to the following terms:** (please initial each item)

I am aware that the practice of psychology/psychiatry/social work/counseling/group counseling treatment is not an exact science. The program staff believes that the treatment strategies employed provide a useful intervention for mental health/substance use problems. I acknowledge that no guarantee can be made concerning the outcome of any evaluation or treatment that may be provided.

I understand that evaluation and treatment will involve the discussion of personal information about my history that, at times, may be uncomfortable.

I agree to participate in the following: (please initial all that apply)

__ Adjustment to Prison	__ Grief and Loss	__ Living with Depression
__ PTSD	__ Release Process Group	__ Stress Mgmt./Relaxation
__ Emotional Regulation Training	__ Living with Co-occurring Disorder	__ Living with Schizophrenia
__ Mood Management	__ Living with Bipolar Disorder	__ Living with OCD

Limitations on Confidentiality: (please initial each item)

GD Process group

I understand my rights of confidentiality apply to all communications with the therapist/counselor, subject to the limitations as described below:

I understand that, while mental health/substance abuse information is confidential, there are exceptions. A therapist is required to disclose confidential information without my consent under certain circumstances that include, but are not limited to, the following:
a) if it is determined that I pose a danger to myself or others or the security of the institution;
b) if I divulge information which would cause the therapist to develop a reasonable belief that I have abused or neglected a minor, and elderly or disabled person, or a member of another protected class; or
c) if I file a suit against the therapist for malpractice.

I understand that, while every effort will be made to guard my confidentiality, because of the nature of group therapy, absolute confidentiality cannot be guaranteed.

Duration of Consent: (please initial each item)

I am aware that I may withdraw my consent at any time with appropriate written notice. However, I agree that this authorization will remain in effect for the duration of all professional mental health/substance abuse services rendered, or until such authorization is revoked by me in writing.

I agree that a photocopy of this form may be used in lieu of the original.

I acknowledge that I have received a copy of the Consent for Mental Health/Substance Use Treatment, that I have read/had the information read to me and understand the information.

I acknowledge I have received a copy of the group expectations and ground rules.

I agree to abide by group expectations and ground rules and understand disciplinary action, as outlined in the handout, may be taken for violating said rules.

M Edmo — OFFENDER SIGNATURE

2-24-14 — DATE

CORIZON
Promote a culture of safety

Food Employee Illness and Lesion Reporting Agreement
Idaho DOC

Preventing transmission of diseases through food by infected food employees with emphasis on illness due to Salmonella Shigella spp., Shiga toxin-producing Escherichia coli, hepatitis A virus, or Norovirus

The purpose of the agreement is to ensure that Food Employees notify the *Person in Charge* when they experience any of the conditions listed so that the *Person in Charge* can take appropriate steps to preclude the transmission of food borneillness.

I AGREE TO REPORT ANY OF THE FOLLOWING TO THE PERSON IN CHARGE:

Future Symptoms and Pustular Lesions:

1. Diarrhea
2. Fever
3. Vomiting
4. Jaundice
5. Sore throat with fever
6. Lesion containing pus on the hand, wrist, or an exposed body part (such as boils and infected wounds, however small)

Future Medical Diagnosis:

Whenever diagnosed as being ill with typhoid fever *(Salmonella typhi)*, shigellosis *(Shigella* spp.), Shiga toxin-producing *Escherichia coli* infection *(Escherichia coli)* 157:H7), hepatitis A (hepatitis A virus), or Norovirus.

Future High-Risk Conditions:

1. Exposure to or suspicion of causing any confirmed outbreak of typhoid fever, shigellosis, Shiga toxin-producing *Escherichia coli* infection, hepatitis A, or Norovirus.
2. A household member diagnosed with typhoid fever, shigellosis, and illness due to Shiga toxin-producing Escherichia *coli,* hepatitis A, or Norovirus.
3. A household member attending or working in a setting experiencing a confirmed outbreak of typhoid fever, shigellosis, Shiga toxin-producing *Escherichia coli* infection, hepatitis A, or Norovirus.

Medical Staff:

Chart/labs checked for infectious disease per SOP 401.06.03.075? ☒ Yes ☐ No

Medical Staff Signature W. Wingert RN DON Date: 10/15/14

William Wingert, R.N., D.O.N.

I have read (or had explained to me) and understand the requirements concerning my responsibilities under the Food Code and this agreement to comply with:

1. Reporting requirements specified above involving symptoms, diagnoses, and high-risk conditions specified;
2. Work restrictions or exclusions that are imposed upon me; and
3. Good hygienic practices.

I understand that failure to comply with the terms of this agreement could lead to action by the food establishment or the food regulatory authority that may jeopardize my employment and may involve legal action against me.

Applicant or Food Employee Name (please print) Mason Edmo

Signature of Applicant or Food employee Mason Edmo IDOC# 94871 DOB [redacted]

Medical Clearance- Food Service Workers

Offenders printed name: Mason Edmo

☒ Offender is medically cleared for Food Service work.
☐ Offender is not cleared for Food Service work

Medical Authorities Signature W. Wingert RN DON Date 10/15/14 Location Corizon @ ISCI 13500 S. Pleasant Valley Rd. Kuna, Idaho 83634

William Wingert, R.N., D.O.N.

This document is to be reviewed with the offender. The original is placed in the medical record and a copy sent to the facility food service.
This form shall be completed for all offenders in RDU and the annually during their birth month.

A63

IDAHO DEPARTMENT OF CORRECTION
CONSENT FOR MENTAL HEALTH/SUBSTANCE ABUSE TREATMENT

INMATE NAME (Last, First, MI)	Edmo, Mason	IDOC #	94691

It is important that you understand the kinds of services you will be provided and the terms and conditions under which these services will be offered.

I, Mason Edmo, am requesting group counseling from the staff of Idaho State Correctional Institution. As a condition of that treatment service, **I acknowledge, understand, and agree to the following terms: (please initial each item)**

ME I am aware that the practice of psychology/psychiatry/social work/counseling/group counseling treatment is not an exact science. The program staff believes that the treatment strategies employed provide a useful intervention for mental health/substance use problems. I acknowledge that no guarantee can be made concerning the outcome of any evaluation or treatment that may be provided.

ME I understand that evaluation and treatment will involve the discussion of personal information about my history that, at times, may be uncomfortable.

I agree to participate in the following: (please initial all that apply)

	Adjustment to Prison		Grief and Loss		Living with Depression
	PTSD		Release Process Group		Stress Mgmt./Relaxation
	Emotional Regulation Training		Living with Bipolar Disorder		Mood Management
	Living with Schizophrenia		Living with Co-occurring Disorder		Living with OCD

Limitations on Confidentiality: (please initial each item)

I understand my rights of confidentiality apply to all communications with the therapist/counselor, subject to the limitations as described below:

ME I understand that, while mental health/substance abuse information is confidential, there are exceptions. A therapist is required to disclose confidential information without my consent under certain circumstances that include, but are not limited to, the following: (a) if it is determined that I pose a danger to myself or others or the security of the institution, (b) if I divulge information which would cause the therapist to develop a reasonable belief that I have abused or neglected a minor, an elderly or disabled person, or a member of another protected class, (c) if I file a suit against the therapist for malpractice.

ME I understand that, while every effort will be made to guard my confidentiality, because of the nature of group therapy, absolute confidentiality cannot be guaranteed.

Duration of Consent: (please initial each item)

ME I am aware that I may withdraw my consent at any time with appropriate written notice. However, I agree that this authorization will remain in effect for the duration of all professional mental health/substance abuse services rendered, or until such authorization is revoked by me in writing.

ME I agree that a photocopy of this form may be used in lieu of the original.

ME I acknowledge that I have received a copy of the Consent for Mental Health/Substance Use Treatment, that I have read/had the information read to me and understand the information.

ME I acknowledge I have received a copy of the group expectations and ground rules.

ME I agree to abide by group expectations and ground rules and understand disciplinary action, as outlined in the handout, may be taken for violating said rules.

INMATE SIGNATURE	M [illegible] Edmo	DATE	7-8-12

CORRECTIONAL MEDICAL SERVICES

CONSENT FOR TREATMENT

Mason D. Edmo — Name of Inmate

7-17-12 — Date

94691 [redacted] — Inmate ID Number/Date of Birth

I hereby give consent to Correctional Medical Services, its employees and agents to perform any diagnostic laboratory procedures, examinations, x-rays, oral or injected medications or other procedures recommended by the physician treating me.

I am aware that the practice of medicine is not an exact science and I acknowledge no guarantees have been made regarding the result of treatments or examinations performed by Correctional Medical Services, it's employees and agents.

I hereby authorize the transfer of my medical records or copies of said records to any facility or provider to which I am referred for treatment or to any other correctional facility to which I am transferred.

I understand I may withdraw this consent to any specific treatment by refusing the treatment or test.

I sign this consent to treatment willingly in full understanding of the above.

Mason Edmo — Inmate Signature

7-17-12 — Date

D Crosley — Witness

Witness

CMS

CORRECTIONAL MEDICAL SERVICES
PSYCHOTROPIC MEDICATION CONSENT FORM

I, Mason Edmo, I.D. 94691, agree to treatment with the following medications in the dosage recommended to me by the psychiatrist:

Lamictal (lamotrigine)

I have been made aware that the following are benefits which may occur through taking these medications:

prevent or reduce manic or depressed moods

I have been made aware that possible side-effects of taking these medications may be:

rash, headache, blurred vision, staggering, nausea, vomiting, increased risk of suicidal ideation and behavior

I voluntarily agree to take the medication(s) listed above as prescribed by the psychiatrist. I understand that this permission may be revoked at my discretion. I have had an opportunity to ask questions I wished to ask.

Karen Barrett MS, PA-C
K. Barrett
Physician's Signature

Date 5/4/12

Mason Edmo
Inmate's Signature

Witness Brooke Olson, LPN

I have been advised to take the medication(s) listed above, but I am unwilling to take the medication as recommended. The possible consequences of not taking the medication have been explained to me. Specifically:

_____

_____

_____

_____
Physician's Signature

_____
Inmate's Signature

CMS 7168 REV. 09/01/04

CORRECTIONAL MEDICAL SERVICES

INFORMED CONSENT AND AGREEMENT TO HIV TESTING

With my signature below, I acknowledge that I have read (or have had read to me) and understand the following information:

Facts about HIV Testing (HIV-1 antibody or other HIV tests)

I HAVE BEEN TOLD THAT: (1) My blood will be tested for signs of an infection by the Human Immunodeficiency Virus (HIV) that causes AIDS; (2) My consent to have my blood tested for HIV is freely given; (3) While every attempt will be made to keep the results of this test confidential, total confidentiality cannot be guaranteed.

What a NEGATIVE test result means:

A. In most instances, a negative test means that a person is not infected, but it can take 3-6 months for the HIV ANTIBODY test to become positive after someone is infected.

B. Although I have a negative test now, I can still become infected by having unprotected sex or by sharing needles.

What a POSITIVE test result means:

A. A positive HIV test means that I have the HIV infection and can spread the virus to others by having sex or by sharing needles.

B. A positive HIV test DOES NOT mean that I have AIDS. Other tests are needed to diagnose AIDS.

C. If my test is positive, I may experience emotional discomfort and, if my test result becomes known in the community, I may experience discrimination in work, personal relationships, and insurance.

What will be done for me if my test is POSITIVE.

A. I will be told what needs to be done to keep me in good health and the treatments available at this institution.

B. I will be told how to keep from spreading my HIV infection by: (1) Avoiding sexual intercourse, or practicing SAFER sex; 2) Not sharing drug needles, or better still, getting off drugs; (3) Not donating or selling my blood, plasma, organs or sperm; (4) Avoiding pregnancy or causing a woman to get pregnant; and (5) Not breastfeeding or donating breast milk.

C. If I have signs or symptoms of HIV infection, upon release, I may contact the local health department to assist me.

D. The local health department can assist me in notifying and referring my partners for care, support and treatment.

I have had a chance to have my questions about this test answered.

I hereby agree to have my blood drawn for HIV antibody test.

Signature	Date	Signature of Counselor
[illegible]	4-26-12	Brooke Olson LVN

Keep original for Medical Records, give copy to inmate.

CMS Revised 09/01/04

CORRECTIONAL MEDICAL SERVICES

CONSENT FOR TREATMENT

Mason Edino
Name of Inmate

4-26-12
Date

94691 / [redacted]
Inmate ID Number/Date of Birth

I hereby give consent to Correctional Medical Services, its employees and agents to perform any diagnostic laboratory procedures, examinations, x-rays, oral or injected medications or other procedures recommended by the physician treating me.

I am aware that the practice of medicine is not an exact science and I acknowledge no guarantees have been made regarding the result of treatments or examinations performed by Correctional Medical Services, it's employees and agents.

I hereby authorize the transfer of my medical records or copies of said records to any facility or provider to which I am referred for treatment or to any other correctional facility to which I am transferred.

I understand I may withdraw this consent to any specific treatment by refusing the treatment or test.

I sign this consent to treatment willingly in full understanding of the above.

Mason Edino
Inmate Signature

4/20/12
Date

Brooke Olson, RN
Witness

Witness

7173 Rev 03/04

MEDICAL APPOINTMENTS and Pill Call

Be Advised:

When you fill out a Health Service Request form, please watch the call out for your scheduled appointment. If you do not see a call out Ask your officer to please post it. It is your responsibility to show up to your medical and dental appointments on time. In addition, pill call is an appointment, and is your responsibility to show up with the rest of your unit. If you nolonger need your appointment or medications you need to come to medical and sign a refusal form at your scheduled appointment time.

Your failure to show up for your scheduled appointments could result in disciplinary action from your officer.

I understand the above information.

Name/ IDOC # 94691 — Date 2/8/10

I have viewed the Blood Born Pathogen Video.

Name/ IDOC# 94691 — Date 2/8/10

CMS

2009 H1N1 In[illegible]za Vaccine
Offender Consent Form

Section 1: Information about Offender Receiving Vaccine (please print)

Name (Last)	(First)	(M.I.)	Date of Birth
Meeks	Mason	D	[redacted]
Facility NICI	**IDOC #** 94691		

Section 2: Questionnaire

	YES	NO
1. Do you have a serious allergy to eggs?	☐	☑
2. Do you have any other serious allergies? Please list:	☐	☑
3. Have you ever had a serious reaction to a previous dose of flu vaccine?	☐	☑
4. Have you ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	☐	☑

Section 3: Consent

CONSENT FOR VACCINATION:
I have read or had explained to me the 2009-2010 Vaccine Information Statement for the 2009 H1N1 influenza vaccine and understand the risks and benefits.

I GIVE CONSENT for H1N1 vaccination.

Signature Mason Meeks

Witness ~~Witness~~ Evans CMS

Date: month 2 day 8 year 2010

I DO **NOT** give consent for H1N1 vaccination

Signature _____

Witness _____

Date: month ____ day ____ year ____

Section 4: Vaccination Record

FOR ADMINISTRATIVE USE ONLY

Vaccine	Date Dose Administered	Route	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator
2 H	H1N1 Vaccine IM-R delt. 0.5 ml. ~~1/11/2010~~ 2/10/10 Manufacturer-CSL Limited Exp. June 30, 2010 Lot. 00149711A Admin. by: I Running CMS				

Telebehav(Health Patient Informatio(J Consent Form

General information

The provision of *mental health services using video-teleconferencing equipment* has significantly increased in the correctional setting. It is simply the electronic exchange of health care information from one site to another for the purpose of providing patient care. Correctional facilities in states like Texas, California, Arizona, New York, Virginia, etc., use this equipment to deliver health care services. Your facility and your *mental health care* Provider will begin using this equipment at your site.

Possible benefits: Increased access to *mental health services* and specialists, increased quality and consistency of care, and decreased weighting times for treatment. **Possible risks:** Equipment failure or faulty transmission, resulting in rescheduling of appointment.

Information for You

You have been referred by your mental health clinician to receive *Telebehavioral Health Services.* Your participation is voluntary and you can choose to see a mental health professional in person if you prefer. If you agree to participate in this program, most of your visits with your mental health professional will be held by live video-teleconfrence; the session will not be recorded on video. Your mental health professional will support the televised visits by meeting with you in person at least every 6 months.

The Telebehavioral Health Program visits will be quite similar to your in-person visits with a mental health professional. The main difference will be that your *mental health professional* will visit you using a camera and monitor that is placed in a room with you. You will be able to see, Hear, talk to, and communicate with the professional and he/she is in the room. Another health care professional will be in the room to assist you during your appointment. Written information in preparation for or regarding your treatment may be transmitted on a secure facsimile to your *mental health professional;* and he/she may send prescriptions, treatment orders, and session notes via secure facsimile to your on sit caregivers or your treating providers.

Even though video cameras will be used, your time with the professional will be as private as being in the same room. No other person can see or hear what you talk about, other then the health care professionals in the room. As before, your visit with the professional is confdential.

Your Consent

By signing below, I Mason Meeks (Print Name) acknowledge and understand that:

I have been fully educated about seeing mental health professional through videoconfrencing equipment.

My video session with the *mental health professional are confidential,* just as if they are in person meetings.

I may ask, at any time, to be seen in person by a *mental health professional* instead of videoconfrencing.
My questions and concerns have been fully addressed.

I am at least 18 years of age, and in full understanding of the above, I willingly consent to participate in the Telebehavioral Health Program and treatment, and use and transfer of information, all as described above.

Mason Meeks 94691 — Signature — 2/8/10 — Date

L Stewart EMS — Witness Healthcare Professional — 2-8-10 — Date

CMS

CORRECTIONAL MEDICAL SERVICES

INFORMED CONSENT AND AGREEMENT TO HIV TESTING

With my signature below, I acknowledge that I have read (or have had read to me) and understand the following information:

Facts about HIV Testing (HIV-1 antibody or other HIV tests)

I HAVE BEEN TOLD THAT: (1) My blood will be tested for signs of an infection by the Human Immunodeficiency Virus (HIV) that causes AIDS; (2) My consent to have my blood tested for HIV is freely given; (3) While every attempt will be made to keep the results of this test confidential, total confidentiality cannot be guaranteed.

What a NEGATIVE test result means:

A. In most instances, a negative test means that a person is not infected, but it can take 3-6 months for the HIV ANTIBODY test to become positive after someone is infected.

B. Although I have a negative test now, I can still become infected by having unprotected sex or by sharing needles.

What a POSITIVE test result means:

A. A positive HIV test means that I have the HIV infection and can spread the virus to others by having sex or by sharing needles.

B. A positive HIV test DOES NOT mean that I have AIDS. Other tests are needed to diagnose AIDS.

C. If my test is positive, I may experience emotional discomfort and, if my test result becomes known in the community, I may experience discrimination in work, personal relationships, and insurance.

What will be done for me if my test is POSITIVE.

A. I will be told what needs to be done to keep me in good health and the treatments available at this institution.

B. I will be told how to keep from spreading my HIV infection by: (1) Avoiding sexual intercourse, or practicing SAFER sex; 2) Not sharing drug needles, or better still, getting off drugs; (3) Not donating or selling my blood, plasma, organs or sperm; (4) Avoiding pregnancy or causing a woman to get pregnant; and (5) Not breastfeeding or donating breast milk.

C. If I have signs or symptoms of HIV infection, upon release, I may contact the local health department to assist me.

D. The local health department can assist me in notifying and referring my partners for care, support and treatment.

I have had a chance to have my questions about this test answered.

I hereby agree to have my blood drawn for HIV antibody test.

Signature	Date	Signature of Counselor
[signature]	11/10	[signature]

Keep original for Medical Records, give copy to inmate.

CORRECTIONAL MEDICAL SERVICES
CONSENT FOR TREATMENT

Mason Meeks — Name of Inmate

1/7/10 — Date

[redacted] — Inmate ID Number/Date of Birth

I hereby give consent to Correctional Medical Services, its employees and agents to perform any diagnostic laboratory procedures, examinations, x-rays, oral or injected medications or other procedures recommended by the physician treating me.

I am aware that the practice of medicine is not an exact science and I acknowledge no guarantees have been made regarding the result of treatments or examinations performed by Correctional Medical Services, it's employees and agents.

I hereby authorize the transfer of my medical records or copies of said records to any facility or provider to which I am referred for treatment or to any other correctional facility to which I am transferred.

I understand I may withdraw this consent to any specific treatment by refusing the treatment or test.

I sign this consent to treatment willingly in full understanding of the above.

Mason Meeks — Inmate Signature

1/7/10 — Date

Witness

Witness

CMS Correctional Medical Services

CORRECTIONAL MEDICAL SERVICES
INFORMED CONSENT

Edmo
Name of Inmate

2-12-13
Date

94691 [redacted]
Inmate ID Number / Date of Birth

I hereby authorize Dr(s). Cushing and Correctional Medical Services employees and agents to perform the following procedure(s):

extraction of teeth

I understand the above procedure(s) is/are necessary to treat my condition and has/have been fully explained. I also understand the nature of any risks associated with this procedure(s), which has/have been explained to me.

I am aware the practice of medicine is not an exact science, and I acknowledge no guarantees have been made as to the outcome of this procedure(s).

I sign this consent willingly and voluntarily in full understanding of the above.

X [signature]
Inmate Signature

2-12-13
Witness

X 1101
Date / Time

[signature] Shayla Massengill, D.A.
Witness

CP7172 Informed Consent Last Reviewed 05/2010 (E-05.01d and I-05.00a)

CMS

CORRECTIONAL MEDICAL SERVICES

PSYCHOTROPIC MEDICATION CONSENT FORM

I, Edmundo Morales, I.D. _____, agree to treatment with the following medications in the dosage recommended to me by the psychiatrist:

Prozac (fluoxetine)

I have been made aware that the following are benefits which may occur through taking these medications:

improved mood, energy, concentration, sleep, appetite, irritability, anxiety, excessive guilt, negative thinking; decreased obsessive thinking and/or repetitive behaviors

I have been made aware that possible side-effects of taking these medications may be:

headache, anxiety, dizziness, fatigue, sedation, sexual dysfunction, nausea, increased risk of suicidal ideation and behavior for 18-24 years olds during the first 2 months of treatment

I voluntarily agree to take the medication(s) listed above as prescribed by the psychiatrist. I understand that this permission may be revoked at my discretion. I have had an opportunity to ask questions I wished to ask.

M. Ellason, M.D.

Physician's Signature

Inmate's Signature

Date 1-16-13

Witness Lois Whitworth, R.N.

I have been advised to take the medication(s) listed above, but I am unwilling to take the medication as recommended. The possible consequences of not taking the medication have been explained to me. Specifically:

_____

_____

_____

Physician's Signature

Inmate's Signature

CMS 7168 REV. 09/01/04

CMS Correctional Medical Services

CORRECTIONAL MEDICAL SERVICES
INFORMED CONSENT

Edmo
Name of Inmate

1913
Date

94691 [redacted]
Inmate ID Number / Date of Birth

I hereby authorize Dr(s). Cushing and Correctional Medical Services employees and agents to perform the following procedure(s):

extraction of teeth #30 #31 #32

I understand the above procedure(s) is/are necessary to treat my condition and has/have been fully explained. I also understand the nature of any risks associated with this procedure(s), which has/have been explained to me.

I am aware the practice of medicine is not an exact science and I acknowledge no guarantees have been made as to the outcome of this procedure(s).

I sign this consent willingly and voluntarily in full understanding of the above.

X Mam Edmo
Inmate Signature

X 1-9-13 @ 1945
Date / Time

Witness

Shayla Massengill, D.A.
Witness

CP7172 Informed Consent Last Reviewed 05/2010 (E-05.01d and I-05.00a)

CORIZON™
Promote a culture of safety

Influenza Campaign 2012-13
Patient
Consent for Vaccine

DEMOGRAPHICS			
Facility			Inmate Number 941691
Inmate Name Mason Edmo			Date of Birth [redacted]
Housing Location	☒ General Population	○ Segregation	Sex: ☒ Male ☐ Female
	○ Infirmary	○ Other	

HISTORY

1. Have you had a flu shot before? ☒ YES ○ NO

If you answer yes to any of the following questions, we will not administer a flu shot.

2. Have you ever had a severe allergic reaction to a flu shot? ○ YES ☒ NO
3. Do you have a severe egg allergy? ○ YES ☒ NO
4. Have you ever had an allergic reaction to any vaccine? ○ YES ☒ NO

*If you answer yes to any of the following questions, we will not administer a flu shot **TODAY**.*

5. Are you currently taking an antibiotic for infection? ○ YES ☒ NO
6. Do you feel ill today or do you have a fever? ○ YES ☒ NO

I state that the above history is true and complete to the best of my knowledge. I received the Vaccine Information Statement: "Influenza Vaccine Inactivated What You Need To Know 2012/2013" CDC form number 42 U.S.C. (7/2/12) §300aa-26 on ___/___/_____ and have been given the opportunity to ask questions.

I understand the benefits and risks of influenza vaccine, and ask that the vaccine be given to me.

Patient Signature: Mason Edmo Date: 10-23-12

INJECTION INFORMATION

Vaccine:	Influenza	Manufacturer:	Afluria CSL Biotherapies
Lot Number:	07249211A	Vaccine Expiration Date:	6/30/13
Site	☑ Right Deltoid ☐ Left Deltoid	Other:	
Stacy McGrew, LPN			10/23/12
Administered by:		Title:	Date

NA0661

CMS Correctional Medical Services

CORRECTIONAL MEDICAL SERVICES
INFORMED CONSENT

Edmo
Name of Inmate

10.3.12
Date

94691 [redacted]
Inmate ID Number / Date of Birth

I hereby authorize Dr(s). Cushing and Correctional Medical Services employees and agents to perform the following procedure(s):

extraction of teeth

I understand the above procedure(s) is/are necessary to treat my condition and has/have been fully explained. I also understand the nature of any risks associated with this procedure(s), which has/have been explained to me.

I am aware the practice of medicine is not an exact science, and I acknowledge no guarantees have been made as to the outcome of this procedure(s).

I sign this consent willingly and voluntarily in full understanding of the above.

Inmate Signature

10-3-12 0924
Date / Time

Witness Shayla Massengill, D.A.

Witness

B 34

IDAHO DEPARTMENT OF CORRECTION
CONSENT FOR MENTAL HEALTH/SUBSTANCE ABUSE TREATMENT

INMATE NAME (Last, First, MI)	Edmo, Mason	IDOC #	94691

It is important that you understand the kinds of services you will be provided and the terms and conditions under which these services will be offered.

I, Mason Edmo, am requesting group counseling from the staff of Idaho State Correctional Institution. As a condition of that treatment service, **I acknowledge, understand, and agree to the following terms: (please initial each item)**

I am aware that the practice of psychology/psychiatry/social work/counseling/group counseling treatment is not an exact science. The program staff believes that the treatment strategies employed provide a useful intervention for mental health/substance use problems. I acknowledge that no guarantee can be made concerning the outcome of any evaluation or treatment that may be provided.

I understand that evaluation and treatment will involve the discussion of personal information about my history that, at times, may be uncomfortable.

I agree to participate in the following: (please initial all that apply)

	Adjustment to Prison		Grief and Loss		Living with Depression
	PTSD		Release Process Group		Stress Mgmt./Relaxation
	Emotional Regulation Training		Living with Bipolar Disorder		Mood Management
	Living with Schizophrenia		Living with Co-occurring Disorder		Living with OCD

Limitations on Confidentiality: (please initial each item)

I understand my rights of confidentiality apply to all communications with the therapist/counselor, subject to the limitations as described below:

I understand that, while mental health/substance abuse information is confidential, there are exceptions. A therapist is required to disclose confidential information without my consent under certain circumstances that include, but are not limited to, the following: (a) if it is determined that I pose a danger to myself or others or the security of the institution, (b) if I divulge information which would cause the therapist to develop a reasonable belief that I have abused or neglected a minor, an elderly or disabled person, or a member of another protected class, (c) if I file a suit against the therapist for malpractice.

I understand that, while every effort will be made to guard my confidentiality, because of the nature of group therapy, absolute confidentiality cannot be guaranteed.

Duration of Consent: (please initial each item)

I am aware that I may withdraw my consent at any time with appropriate written notice. However, I agree that this authorization will remain in effect for the duration of all professional mental health/substance abuse services rendered, or until such authorization is revoked by me in writing.

I agree that a photocopy of this form may be used in lieu of the original.

I acknowledge that I have received a copy of the Consent for Mental Health/Substance Use Treatment, that I have read/had the information read to me and understand the information.

I acknowledge I have received a copy of the group expectations and ground rules.

I agree to abide by group expectations and ground rules and understand disciplinary action, as outlined in the handout, may be taken for violating said rules.

INMATE SIGNATURE	Mason Edmo	DATE	2-10-13

Telebehavioral Health Patient Information and Consent Form

General Information

The provision of *mental health services using video-teleconferencing equipment* has significantly increased in the correctional setting. It is simply the electronic exchange of health care information from one site to another for the purpose of providing patient care. Correctional facilities in states such as Texas, California, Arizona, New York, Virginia, etc., use this equipment to deliver health care services. Your facility and your *mental health care* provider will begin using this equipment at your site.

Possible benefits: Increased access to *mental health services and specialists*, increased quality and consistency of care, and decreased waiting times for treatment. **Possible risks:** Equipment failure or faulty transmission, resulting in rescheduling of appointment.

Information for You

You have been referred by your *mental health clinician* to receive *Telebehavioral Health Services*. Your participation is *voluntary* and you can choose to see a *mental health professional* in person if you prefer. If you agree to participate in this program, most of your visits with your *mental health professional* will be held by live video-teleconference; the sessions will NOT be recorded on video. Your *mental health professional* will support the televised visits by meeting with you in person at least every six months.

The *Telebehavioral Health Program* visits will be quite similar to your in-person visits with a *mental health professional*. The main difference will be that your *mental health professional* will visit with you using a camera and monitor that is placed in the room with you. You will be able to see, talk to, and communicate with the professional as if he/she is in the room. In other words, you will be able to see, hear, and talk to the professional and he/she will be able to see, hear, and talk to you. Another health care professional may be in the room to assist you during your appointment. Written information in preparation for or regarding your treatment may be transmitted on a secure facsimile to your *mental health professional*; and he/she may send prescription, treatment orders, and session notes via secure facsimile to your onsite caregivers or your other treating providers.

Even though video cameras will be used, your time with the professional will be as private as being in the same room. No other person can see or hear what you talk about, other than the *health care professional* in the room. As before, your visit with the professional is confidential.

Your Consent

By signing below, I Mason Edmo [print name] acknowledge and understand that:

I have been fully educated about seeing the Mental Health Professional *through videoconferencing equipment.*

My video sessions with the professional are *confidential*, just as if they are in person meetings.

I may ask, at any time, to be seen *in person* by a Mental Health Professional instead of videoconference.

My questions and concerns have been *fully addressed.*

I am at least 18 years of age, and in full understanding of the above, I willingly consent to participate in the Telebehavioral Health program and treatment, and use and transfer of information, all as described above.

Mason Edmo — *Signature* — 9/12/13 — *Date*

[illegible] RN — *Witness/Healthcare Professional* — 9/12/13 — *Date*

CORIZON™
Promote a culture of safety

Influenza Campaign 2013-14
Patient
Consent for Vaccine

DEMOGRAPHICS			
Facility ICIO			Inmate Number 94691
Inmate Name Edna, Mason			Date of Birth [redacted]
Housing Location	☒ General Population	○ Segregation	Sex: ☒ Male ☐ Female
B-2	○ Infirmary	○ Other	

HISTORY		
1. Have you had a flu shot before? (¿Le han aplicado una inyección contra la influenza anteriormente?)	○ YES(Si)	☒ NO
If you answer yes to any of the following questions, we will not administer a flu shot. (Si responde "si" a alguna de las siguientes preguntas, no le administraremos la inyección contra la influenza.)		
2. Have you ever had a severe allergic reaction to a flu shot? (¿Alguna vez ha tenido una reacción alérgica grave a una inyección contra la influenza?)	○ YES(Si)	☒ NO
3. Do you have a severe egg allergy? (¿Es alérgico al huevo?)	○ YES(Si)	☒ NO
4. Have you ever had an allergic reaction to any vaccine? (¿Ha tenido alguna reacción alérgica a alguna vacuna?)	○ YES(Si)	☒ NO
*If you answer yes to any of the following questions, we will not administer a flu shot **TODAY**. (Si responde "si" a alguna de las siguientes preguntas, no le administraremos la inyección contra la influenza **HOY**.)*		
5. Are you currently taking an antibiotic for infection? (¿Actualmente está tomando algún antibiótico para una infección?)	○ YES(Si)	☒ NO
6. Do you feel ill today or do you have a fever? (¿Se siente enfermo o tiene fiebre hoy?)	○ YES(Si)	☒ NO

I state that the above history is true and complete to the best of my knowledge. I received the Vaccine Information Statement: "Influenza Vaccine Inactivated What You Need To Know 2013/2014" CDC form number 42 U.S.C. (7/26/13) §300aa-26 on 10/14/13 and have been given the opportunity to ask questions.

(Afirmo que los antecedentes anteriores son verdaderos y completos a mi leal saber y entender. Recibí la Declaración de Información de la Vacuna: "Lo que necesita saber sobre la Vacuna inactivada contra la influenza 2013/2014", número de formulario CDC 42 U.S.C. (7/26/13), Sección 300aa-26,el __/__/____y se me dio la oportunidad de hacer preguntas.)

I understand the benefits and risks of influenza vaccine, and ask that the vaccine be given to me.
(Comprendo los beneficios y los riesgos de la vacuna contra la influenza y solicito que se me administre).

Patient Signature(Firma del paciente)	Date (Fecha)
Mary Edna	10/14/13

INJECTION INFORMATION (INFORMACIÓN DE INYECCIÓN)					
Vaccine:	Flu		Manufacturer:	GSK	
Lot Number:	XJ595		Vaccine Expiration Date:	06/2014	
Site	☐ Right Deltoid	☑ Left Deltoid	Other:		
Brown		RN		10/14/13	
Administered by:		Title:		Date	

NA0662
08/2013

CMS

CORRECTIONAL MEDICAL SERVICES

PSYCHOTROPIC MEDICATION CONSENT FORM

I, Mason Edmo, I.D. 94651, agree to treatment with the following medications in the dosage recommended to me by the psychiatrist:

Zoloft (sertraline)

I have been made aware that the following are benefits which may occur through taking these medications:

improved mood, energy, concentration, sleep, appetite, irritability, anxiety, excessive guilt, negative thinking

I have been made aware that possible side-effects of taking these medications may be:

headache, anxiety, dizziness, fatigue, sedation, sexual dysfunction, nausea, increased risk of suicidal ideation and behavior for 18-24 years olds during the first 2 months of treatment

I voluntarily agree to take the medication(s) listed above as prescribed by the psychiatrist. I understand that this permission may be revoked at my discretion. I have had an opportunity to ask questions I wished to ask.

Dr Montgomery
Physician's Signature

M Edmo
Inmate's Signature

Date 10-8-13

Witness

I have been advised to take the medication(s) listed above, but I am unwilling to take the medication as recommended. The possible consequences of not taking the medication have been explained to me. Specifically:

_____

_____

_____

Physician's Signature

Inmate's Signature

CMS 7168 REV. 09/01/04

at ICIO

IDAHO DEPARTMENT OF CORRECTION
CONSENT FOR MENTAL HEALTH/SUBSTANCE ABUSE TREATMENT

INMATE NAME (Last, First, MI)	Edmo, Mason	IDOC #	94691

It is important that you understand the kinds of services you will be provided and the terms and conditions under which these services will be offered.

I, _am requesting group counseling from the staff of Idaho State Correctional Institution. As a condition of that treatment service, **I acknowledge, understand, and agree to the following terms: (please initial each item)**

I am aware that the practice of psychology/psychiatry/social work/counseling/group counseling treatment is not an exact science. The program staff believes that the treatment strategies employed provide a useful intervention for mental health/substance use problems. I acknowledge that no guarantee can be made concerning the outcome of any evaluation or treatment that may be provided.

_____ I understand that evaluation and treatment will involve the discussion of personal information about my history that, at times, may be uncomfortable.

I agree to participate in the following: (please initial all that apply)

	Adjustment to Prison		Grief and Loss		Living with Depression
	PTSD		Release Process Group		Stress Mgmt./Relaxation
	Emotional Regulation Training		Living with Bipolar Disorder		Mood Management
	Living with Schizophrenia		Living with Co-occurring Disorder		Living with OCD

Limitations on Confidentiality: (please initial each item)

I understand my rights of confidentiality apply to all communications with the therapist/counselor, subject to the limitations as described below:

I understand that, while mental health/substance abuse information is confidential, there are exceptions. A therapist is required to disclose confidential information without my consent under certain circumstances that include, but are not limited to, the following: (a) if it is determined that I pose a danger to myself or others or the security of the institution, (b) if I divulge information which would cause the therapist to develop a reasonable belief that I have abused or neglected a minor, an elderly or disabled person, or a member of another protected class, (c) if I file a suit against the therapist for malpractice.

_____ I understand that, while every effort will be made to guard my confidentiality, because of the nature of group therapy, absolute confidentiality cannot be guaranteed.

Duration of Consent: (please initial each item)

I am aware that I may withdraw my consent at any time with appropriate written notice. However, I agree that this authorization will remain in effect for the duration of all professional mental health/substance abuse services rendered, or until such authorization is revoked by me in writing.

_____ I agree that a photocopy of this form may be used in lieu of the original.

_____ I acknowledge that I have received a copy of the Consent for Mental Health/Substance Use Treatment, that I have read/had the information read to me and understand the information.

_____ I acknowledge I have received a copy of the group expectations and ground rules.

_____ I agree to abide by group expectations and ground rules and understand disciplinary action, as outlined in the handout, may be taken for violating said rules.

INMATE SIGNATURE		DATE	

Correctional Medical Services

ACCESS TO MEDICAL SERVICES INFORMATION
AND
EDUCATION MATERIALS RECEIPT FORM

Mason Meeks
Offender's Name (Print)

IDOC#

You are being provided with information on how to access medical, mental health and dental service while here at the Idaho State Correctional Institution. Medical educational materials are posted.

Access to Medical Service:

- Health Services Notice
- Instruction for Sick Call Request
- Medical Co-Payment

Medical Educational Materials:

- Nutrition
- Personal Hygiene
- Hair Care
- Physical Fitness
- Dental Care
- Tuberculosis
- HIV
- Testicular Cancer
- Hepatitis C
- MRSA

Offender's Signature | IDOC# | Date 1/7/10

Witness | Title LMS | Date 1.7.10

Correctional Medical Services

ACCESS TO MEDICAL SERVICES INFORMATION
AND
EDUCATION MATERIALS RECEIPT FORM

Mason Edmo
Offender's Name (Print)

94691
IDOC #

You are being provided with information on how to access medical, mental health, and dental service while here at the Idaho State Correctional Institution. Medical education materials are posted.

Access to Medical Service:
- Health Services Notice
- Instruction for Sick Call Request
- Medical Co-Payment

Medical Education Materials:
- Nutrition
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- Hair Care
- Physical Fitness
- Dental Care
- Tuberculosis
- HIV
- Testicular Cancer
- Hepatitis C
- MRSA

Mason Edmo	94691	4-26-12
Offender's Signature	IDOC #	Date
Brooke Olsen, LPN	LPN	4/27/12
Witness	Title	Date

CENTRAL DISTRICT HEALTH DEPARTMENT

Serving Valley, Elmore, Boise and Ada Counties

Boise Office: 707 N. Armstrong Place 327-7499 Boise ID 83704
McCall Office: 703 N. 1st Street 634-7194 McCall ID 83638
Mountain Home Office: 520 E 6th North 587-9225 Mountain Home ID 83647

Food Employee Illness and Lesion Reporting Agreement

Preventing transmission of diseases through food by infected food employees with emphasis on illness due to Salmonella typhi, Shigella spp., Shiga toxin-producing Escherichia coli, hepatitis A virus, or Norovirus

The purpose of the agreement is to ensure that Food Employees notify the *Person in Charge* when they experience any of the conditions listed so that the *Person in Charge* can take appropriate steps to preclude the transmission of foodborne illness.

I AGREE TO REPORT ANY OF THE FOLLOWING TO THE PERSON IN CHARGE:

Future Symptoms and Pustular Lesions:

1. Diarrhea
2. Fever
3. Vomiting
4. Jaundice
5. Sore throat with fever
6. Lesion containing pus on the hand, wrist, or an exposed body part (such as boils and infected wounds, however small)

Future Medical Diagnosis:

Whenever diagnosed as being ill with typhoid fever (*Salmonella typhi*), shigellosis (*Shigella* spp.), Shiga toxin-producing *Escherichia coli* infection (*Escherichia coli* 157:H7), hepatitis A (hepatitis A virus), or Norovirus.

Future High-Risk Conditions:

1. Exposure to or suspicion of causing any confirmed outbreak of typhoid fever, shigellosis, Shiga toxin-producing *Escherichia coli* infection, hepatitis A, or Norovirus.
2. A household member diagnosed with typhoid fever, shigellosis, illness due to Shiga toxin-producing *Escherichia coli*, hepatitis A, or Norovirus.
3. A household member attending or working in a setting experiencing a confirmed outbreak of typhoid fever, shigellosis, Shiga toxin-producing *Escherichia coli* infection, hepatitis A, or Norovirus.

HEALTH EDUCATION

FOOD SERVICE WORKER GUIDELINES

HAIRNETS

(If applicable as health department or site requirement)

1. Put hairnet on before washing hands.
2. Be sure to include all hair, especially bangs on the front of the head.
3. Do not touch hair or hairnet when handling food.

HANDWASHING

1. Turn warm water on.
2. Wet hands.
3. Lather hands with soap. Scrub at least 30 seconds.
4. Rinse off bar of soap. Replace in soap dish.
5. Rinse hands.
6. Dry hands with paper towels.
7. Turn faucet off with paper towels.

SICKNESS

Tell kitchen officer if you feel ill, or if you have diarrhea or a rash.

I have received education on hand washing and personal hygiene, and I understand the need for both, especially when handling food on kitchen detail.

Inmate Signature

4/27/12

Date

Brooke

Instructor Signature

4/27/12

Date

I have read (or had explained to me) and understand the requirements concerning my responsibilities under the Food Code and this agreement to comply with:

1. Reporting requirements specified above involving symptoms, diagnoses, and high-risk conditions specified;
2. Work restrictions or exclusions that are imposed upon me; and
3. Good hygienic practices.

I understand that failure to comply with the terms of this agreement could lead to action by the food establishment or the food regulatory authority that may jeopardize my employment and may involve legal action against me.

Applicant or Food Employee Name (please print) Mason Edmo offender

Signature of Applicant or Food Employee Mason Edmo offender

Signature of Permit Holder's Representative IDOC location

IDOC Medical Clearance for Food Service Workers

Offender's Printed Name Edmo IDOC # 94691

☒ This inmate is **medically cleared** for duty as a food service worker.

☐ This inmate is **not medically cleared** for duty as a food service worker.

Medical Staff Signature [redacted] Olsen, LPN Date 1/27/10

Return a copy of this completed document to Food Service.

Common/env/food/foodemplIness-revised-4/08-jh

2009 revised for IDOC

NORTH IDAHO CORRECTIONAL INSTITUTION
NEW ARRIVAL ORIENTATION & ACCESS TO MEDICAL SERVICES

1. **HEALTH SERVICES REQUEST FORM: (kite)**
   A. Health Services Request Forms (HSRF or kite) are available in all living units.
   B. HSRF must be filled out completely, including name, number, barracks **or they will be returned to you and you will have to submit another HSRF.**
   C. HSRF must be placed in the medical box Located in the dining Hall before 1600 hrs.
2. CLINICS:
   A. Nursing Clinics (Sick Call) are held Mon- Fri. at 8:00am and 1330pm if necessary. The Physicians Assistant (PA) Clinic is held Tuesday at 8:00am. **No holidays, and No weekends**. There will be medical personnel on the compound 7 days a week if you have an emergency.
   B. A Medical Call Out list will be posted by graveyard unit officer in each barracks by 0600 daily. Twice a month a Dental Call Out list is placed in all barracks. Once weekly on Tuesdays a Mental Health Callout list is placed in the barracks along with the regular Medical Call Out list. **It is your responsibility to be ready for the appointment and to be on time. Do not Expect us to call you to medical. Even if the problem has stopped, come to medical to sign a form for refusal of treatment and you will not be charged.**
   C. If you have submitted a HSRF you will be seen by medical staff within 72 hrs.
   D. **The medical department is an unauthorized area. You are only to be there if you are on the medical call out, if medical staff has sent for you, or another staff member has sent you to medical.**
   E. There will be a $3.00 charge for each medical or dental appointment/ request and a $2.00 charge for each prescription that is issued to you.
3. TRAINING
   A. Blood and body fluids Precautions (video) training is done during Medical orientation.
4. MEDICATIONS AND PILL CALL:
   A. Pill call is 2 times daily, AM pill call begins at 0530. PM pill call is held immediately after chow. Morning & Evening Pill Call will be announced by the unit officers, but the 12pm will not & you will have to come on your own to pill call if you are on meds at this 12pm time.
   B. Controlled medications are issued twice daily at pill call times.
   C. Diabetics report to medical twice daily, pill call in the morning and 1530 hrs in the afternoon.
   D. Keep on person medication refills are issued as needed at pill call, pick them up at 0800 KOP exchange pill call on the day that you run out, with the Empty Card in hand or no new card will be issued to you.
   E. If you are requesting a refill of over the counter medication Please put in a medical request. We will re-evaluate your problem to determine the need for more medication. **You will be charged $2.00 for these refills.**
   F. Keep your medication in a safe place. **You are responsible for your medications.**
   G. **Never share your medications with anyone else.**
   H. It is very important to take all medications as medical has instructed. If you have any doubts on the instructions come to medical and ask.
   I. There is no announcement for medical if you are on meds other than the morning and evening pill calls. You will have to **COME ON YOUR OWN!**

YOU WILL NOT BE DENIED MEDICAL CARE IF YOU ARE UNABLE TO PAY. Place a medical kite in the medical box and the medical department will treat you for the medical problem requiring medical attention.

Inmate Signature	IDOC #	Date	Medical Staff
[signature]	94691	2/8/10	[signature] CMS

IDAHO MAXIMUM SECURITY INSTITUTION

I HAVE BEEN INSTRUCTED ON HOW TO ACCESS EMERGENCY HEALTH ISSUES BOTH VERBALLY, AND IN WRITING.

I ALSO HAVE BEEN INSTRUCTED ON THE PROCEDURE FOR RECEIVING MEDICATION, BOTH FOR KEEP ON PERSON AND PILL CALL.

I UNDERSTAND THE INSTRUCTIONS AND HAVE NO QUESTIONS AT THIS TIME.

Juan Edyno 74691 — 7-17-12

(INMATE SIGNATURE & IDOC NUMBER) (DATE)

[signature] — 7/17/12

(WITNESS) (DATE)

CENTRAL DISTRICT HEALTH DEPARTMENT

Serving Valley, Elmore, Boise and Ada Counties

Boise Office: 707 N. Armstrong Place 327-7499 Boise ID 83704
Mc Call Office: 703 N. 1st Street 634-7194 Mc Call ID 83638
Mountain Home Office: 520 E 8th North 587-9225 Mountain Home ID 83647

Food Employee Illness and Lesion Reporting Agreement

Preventing transmission of diseases through food by infected food employees with emphasis on illness due to Salmonella typhi, Shigella spp., Shiga toxin-producing Escherichia coli, hepatitis A virus, or Norovirus

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I AGREE TO REPORT ANY OF THE FOLLOWING TO THE PERSON IN CHARGE:

Future Symptoms and Pustular Lesions:

1. Diarrhea
2. Fever
3. Vomiting
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5. Sore throat with fever
6. Lesion containing pus on the hand, wrist, or an exposed body part (such as boils and infected wounds, however small)

Future Medical Diagnosis:

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2. A household member diagnosed with typhoid fever, shigellosis, illness due to Shiga toxin-producing *Escherichia coli*, hepatitis A, or Norovirus.
3. A household member attending or working in a setting experiencing a confirmed outbreak of typhoid fever, shigellosis, Shiga toxin-producing *Escherichia coli* infection, hepatitis A, or Norovirus.

I have read (or had explained to me) and understand the requirements concerning my responsibilities under the Food Code and this agreement to comply with:

1. Reporting requirements specified above involving symptoms, diagnoses, and high-risk conditions specified;
2. Work restrictions or exclusions that are imposed upon me; and
3. Good hygienic practices.

I understand that failure to comply with the terms of this agreement could lead to action by the food establishment or the food regulatory authority that may jeopardize my employment and may involve legal action against me.

Applicant or Food Employee Name (please print) Edmo

Signature of Applicant or Food Employee * Mason Edmo

Signature of Permit Holder's Representative Corizon @ ISCI 13500 S. Pleasant Valley Rd. Kuna, Idaho 83634

Medical Clearance - Food Service Workers

Offender's Printed Name Mason Edmo # 94691 DOB [redacted]

✓ Offender is medically cleared for Food Service work.

____ Offender is **not** medically cleared for Food Service work.

Medical Authorities Signature M. Margaret, RN Date 10/16/12 Location ISCI

This document should be reviewed with the offender. The original should be placed in the medical file and a photocopy (with signatures) should be sent to the facility food service operation as requested. This form should be completed for all offenders in RDU and annually during their birth month.

Common/env/food/foodempillness revised 4/08 jh

CENTRAL DISTRICT HEALTH DEPARTMENT

Serving Valley, Elmore, Boise and Ada Counties

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Idaho Correctional Institution Orofino
Medical Services

ACCESS TO MEDICAL SERVICES INFORMATION
&
EDUCATIONAL MATERIALS RECEIPT

Edmo, Mason
Inmate Name

94691
IDOC #

You are being provided with information on how to access medical, mental health and dental service while here at Idaho Correctional Institution Orofino. Additionally, you are being furnished with medical educational materials.

Access to Medical Service:

- Health Services Notice
- Instruction for Sick Call Request
- Medical Co-Payment

Medical Educational Materials:

- Nutrition
- Personal Hygiene
- Physical Fitness
- Tuberculosis
- HIV
- Testicular Exam
- Hepatitis C
- MRSA
- Smoking Cessation

Mason Edmo	94691	8-12-13
Inmate Signature	IDOC #	Date
Witness Tammy Miller, RN	RN	8/12/13
	Title	Date

CORIZON HEALTH SERVICES
HEALTH SERVICES NOTICE

ACCESS TO HEALTH CARE

NOTIFICATION OF MEDICAL SERVICES: Corizon Health Services provides the medical care at this facility. If you have any special medical or emotional problems, please be sure to inform the nurse or doctor of your problem at the time of your interview with them.

HOW TO SIGN UP FOR SICK CALL: If during your incarceration you wish to see the nurse or doctor concerning a problem, submit a medical Health Services Request form stating your problem and put it in the medical sick call box. Medical requests are collected daily and reviewed by the appropriate medical personnel.

HOW TO INFORM STAFF OF A MEDICAL EMERGENCY: If you have an emergency medical problem, please contact your officer immediately. The officer will contact the proper medical person or hospital to handle your problem. If you have any questions about medical services provided within this institution or how to properly contact the appropriate person, please refer your questions to your officer or to a nurse for clarification.

ACCESS TO DENTAL CARE: Submit a medical Health Services Req1uest form stating your problem, put it in the medical sick call box. If you have a Dental Emergency, please contact your officer immediately. The officer will contact the proper medical personnel to handle your problem.

AVISO DE SERVICIOS MEDICOS: Medico Servicio provee asistencia medica en esta institucion. Cualquier problema emocional o fisico usted puede informar y hablar con la enfermera o medico.

COMO OBTENER SERVICIO MEDICO: Si durante el tiempo, en que usted esta en esta institucion desea visitar a la enfermera o al medico puede llenar un papel medico para el doctor o la enfermera. Luego, ponga el papel en la caja de solicitudes medicas. Estas listas seran recogidas diariamente y revisadas por e personal medico indicado.

COMO INFORMAR DE UNA EMERGENCIA MEDDDICA: Si tiene una emergencia medica llame al sargento de official imediamente. Si tiene preguntas de medico puede hablar con una enfermera. Si no sabe con quien hablar puede hablar con su sargento.

ACCESO ATENCION – DENTAL: Ponga una solicitud medica escribiendo su problema. Ponga la solicitud dentro del cajon/marcado (MEDICAL). Si tiene una emergencia Dental, puede avisar su sargento y el se comunicara con la persona apropiada para su problema.

MEDICAL APPOINTMENTS AND PILL CALL

Be Advised:

When you fill out a Health Service Request form, please watch, the call out for your scheduled appointment. If you do not see a call out ask your unit officer.

It is your responsibility to show up to your medical and dental appointments on time. In addition, pill call is an appointment, and is your responsibility to show up with rest of your unit. If you no longer need your appointment or medications you need to come to medical and sign a refusal form at your scheduled appointment time.

Your failure to show up to show up for your scheduled appointments could result in disciplinary action.

I understand the above information.

Name/IDOC # Mam Edmo 94691

Date 8-12-13

Edmo
94691

Medical Staff:

Labs reviewed for infectious diseases? ☑ Yes ☐ No

Medical Staff Signature Tammy Miller RN Date 8/12/13

Tammy Miller, RN

I have read (or had explained to me) and understand the requirements concerning my responsibilities under the Food Code and this agreement to comply with:

1. Reporting requirements specified above involving symptoms, diagnoses, and high-risk conditions specified;
2. Work restrictions or exclusions that are imposed upon me; and
3. Good hygienic practices.

I understand that failure to comply with the terms of this agreement could lead to action by the food establishment or the food regulatory authority that may jeopardize my employment and may involve legal action against me.

Applicant or Food Employee Name (please print) Edwin Masan IDOC#:

Signature of Applicant or Food employee

Signature of Permit Holder's Representative Tammy Miller RN

Tammy Miller, RN

Food Worker Clearance

Medical Staff:

Chart/labs checked for Infectious disease per SOP 401.06.03.075? ☒ Yes ☐ No

Medical Staff Signature _____ Sharon Brown, RN

Date: 10/20/13

I have read (or had explained to me) and understand the requirements concerning my responsibilities under the Food Code and this agreement to comply with:

1. Reporting requirements specified above involving symptoms, diagnoses, and high-risk conditions specified;
2. Work restrictions or exclusions that are imposed upon me; and
3. Good hygienic practices.

I understand that failure to comply with the terms of this agreement could lead to action by the food establishment or the food regulatory authority that may jeopardize my employment and may involve legal action against me.

Applicant or Food Employee Name (please print) Edmo. Mason

Signature of Applicant or Food employe _____

IDOC # 94691

Medical Clearance- Food Service Workers

Offenders printed name: Edmo. Mason

X Offender **is** medically cleared for Food Service work.

_____ Offender is **not** cleared for Food Service work

Medical Authorities Signature _____ Sharon Brown, RN Date 10/20/13

Location ICIO - C1

This document is to be reviewed with the offender. The original is placed in the medical record and a copy sent to the facility food service. This form shall be completed for all offenders in RDU and the annually during their birth month.

CENTRAL DISTRICT HEALTH DEPARTMENT

Serving Valley, Elmore, Boise and Ada Counties

Boise Office: 707 N. Armstrong Place 327-7499 Boise ID 83704
Mc Call Office: 703 N. 1st Street 634-7194 Mc Call ID 83638
Mountain Home Office: 520 E 8th North 587-9225 Mountain Home ID 83647

Food Employee Illness and Lesion Reporting Agreement

Preventing transmission of diseases through food by infected food employees with emphasis on illness due to Salmonella Shigella spp., Shiga toxin-producing Escherichia coli, hepatitis A virus, or Norovirus

The purpose of the agreement is to ensure that Food Employees notify the *Person in Charge* when they experience any of the conditions listed so that the *Person in Charge* can take appropriate steps to preclude the transmission of food borne illness.

I AGREE TO REPORT ANY OF THE FOLLOWING TO THE PERSON IN CHARGE:

Future Symptoms and Pustular Lesions:

1. Diarrhea
2. Fever
3. Vomiting
4. Jaundice
5. Sore throat with fever
6. Lesion containing pus on the hand, wrist, or an exposed body part (such as boils and infected wounds, however small)

Future Medical Diagnosis:

Whenever diagnosed as being ill with typhoid fever *(Salmonella typht)*, shigellosis *(Shigella* spp.), Shiga toxin-producing *Escherichia coli* infection *(Escherichia colt)* 157:H7), hepatitis A (hepatitis A virus), or Norovirus.

Future High-Risk Conditions:

1. Exposure to or suspicion of causing any confirmed outbreak of typhoid fever, shigellosis, Shiga toxin-producing *Escherichia coli* infection, hepatitis A, or Norovirus.
2. A household member diagnosed with typhoid fever, shigellosis, and illness due to Shiga toxin-producing Escherichia *coli,* hepatitis A, or Norovirus.
3. A household member attending or working in a setting experiencing a confirmed outbreak of typhoid fever, shigellosis, Shiga toxin-producing *Escherichia coli* infection, hepatitis A, or Norovirus.

RECREATION LIST YARD/GYM
Inmate is allowed all privileges of his custody but may not engage in sports activity or strenuous exercise as determined by medical staff. Status may be modified on this form by specifying certain restrictions or limitations. For example, an inmate who is restricted to "NO JUMPING" may still engage in less strenuous activities such as table tennis, pool, and horseshoes. Specific sports may likewise be identified. For example, "NO BASKETBALL", "NO SOFTBALL", ETC. Since medical staff does not have continuous contact with the inmates, it's the judgment of the security staff, which is generally applied to stipulations and or limitations. If necessary, areas of concern will be resolved between medical and security staff, not between the inmate and staff.

MEDICAL LAY IN
Inmate is confined to his cell or bunk. Inmate may leave his cell or bunk area for meals, medical attention, legal obligations (attorney visits, court, etc.), mandatory call outs by security staff, and bathroom privileges.

MEDICAL IDLE
Inmate is allowed all privileges of his custody but is excused from work for a specified period of time.

LOWER BUNK
Authorization is contingent upon availability and the severity of the offender's medical problem. This authorization is coordinated between medical and security staff.

WORK LIMITATIONS
This is similar to light duty status and implies some restriction or limits related to work. "No lifting greater than 20 lbs." is an example.

FOOD HANDLING
This implies that the inmate has a condition, which would prohibit working in or around food preparation for a temporary or permanent length of time.

OTHER
As described specifically on the front.

I, the undersigned, hereby authorize Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with my dental care, and further authorize and consent that Doctor choose and employ such assistance as he deems fit.

I also understand the use of anesthetic agents embodies a certain risk.

I have reviewed the above medical history, and there have been no changes in my medical history. I attest that the above information is accurate to the best of my knowledge.

Maria Mesta — 1/7/10

SIGNATURE — DATE

No change ☐	Signature	Date
No change ☐	Signature	Date
No change ☐	Signature	Date
No change ☐	Signature	Date
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No change ☐	Signature	Date
No change ☐	Signature	Date

CORIZON HEALTH

Transgender MTF Hormone Therapy Consent

AM Patient information provided- goals and possible side-effects of treatment

AM Medical screening completed- all questions have been answered.

AM I give my voluntary consent for hormone and other possible drug therapy to induce development of female characteristics.

AM I agree to have regular follow-up visits for physical examination and laboratory testing, and that failure to do so will interrupt the therapy or stop it altogether.

AM I agree to take the medications only as prescribed, and to inform the medical provider of any possible problems. If I take the medications in a dosage that is different than the prescribed dosage or if additional sources of hormones are discovered, the therapy will be discontinued.

AM I agree to participate and cooperate in the management of other medical problems that must be controlled in order for the therapy to be safe, for example, diabetes, obesity, tobacco use, high cholesterol, etc. I acknowledge that tobacco use disqualifies me from receiving the therapy.

AM I understand that I can discontinue therapy at any time. I also understand that the medical provider will discontinue therapy if a medical problem is discovered that causes the therapy to become unsafe.

Patient Name: Meyerfeldt IDOC #: 94691 Date: 12/14/16

Patient Signature: _____ Witness Signature: _____

Updated August, 2016

CORIZON

Hormone Therapy

Consent for Treatment

I, Mason, Edmo, I.D.O.C. #_____, understand the risks associated with hormone therapy and agree to treatment with the following medications in the dosage recommended to me by the provider:

- Estradiol 3 mg BID sublingually (6 mg)
- Spironolacton 150 mg BID (300 mg)
- Finasteride 5 mg daily (5 mg)
- Medroxyprogesteron 10 mg daily (10 mg)

I have been made aware of the following effects which may occur through taking these medications:

- **Cross sex hormones may reduce fertility. This may be permanent even after hormones are discontinued.**
- **Estrogen may have the effect of reducing libido, erectile function and ejaculation.**
- **Testosterone generally increases libido.**
- **Hormone therapy may result in increased risk of thromboembolism (DVT/PE) especially in individuals who smoke.**
- **CVA (stroke).**
- **MI (heart attack).**
- **Hepatic neoplasia (liver cancer).**
- **Gallbladder disease.**

I voluntarily agree to take the medication(s) listed above as prescribed. I understand that this permission may be revoked at my discretion. I have had an opportunity to ask questions I wished to ask.

_____ Date: 12/14/16
Physician's Signature

_____ IDOC# D/14/16
Patient's Signature

Date_____

CORIZON HEALTH

Influenza Campaign 2016-17
Patient
Consent or Refusal for Vaccine

DEMOGRAPHICS			
Facility	Idaho State Correctional Institution		Inmate Number 94691
Inmate Name	Edmund Mason		Date of Birth
Housing Location	☒ General Population	○ Segregation	Sex: ☒ Male ☐ Female
	○ Infirmary	○ Other	

HISTORY

1.	Have you had a flu shot before? (¿Le han aplicado una inyección contra la influenza anteriormente?)	☒ YES(SI)	○ NO
	If you answer yes to any of the following questions, we will not administer a flu shot. (Si responde "sí" a alguna de las siguientes preguntas, no le administraremos la inyección contra la influenza.)		
2.	Have you ever had a severe allergic reaction to a flu shot? Guillian-Barre Syndrome (GBS)? (¿Alguna vez ha tenido una reacción alérgica grave a una inyección contra la influenza?)	○ YES(Si)	☒ NO
3.	Do you have a severe egg allergy? (¿Es alérgico al huevo?)	○ YES(Si)	☒ NO
4.	Have you ever had an allergic reaction to any vaccine? (¿Ha tenido alguna reacción alérgica a alguna vacuna?)	○ YES(Si)	☒ NO
	*If you answer yes to any of the following questions, we will not administer a flu shot **TODAY**. (Si responde "sí" a alguna de las siguientes preguntas, no le administraremos la inyección contra la influenza **HOY**.)*		
5.	Are you currently taking an antibiotic for infection? (¿Actualmente está tomando algún antibiótico para una infección?)	○ YES(Si)	☒ NO
6.	Do you feel ill today or do you have a fever? (¿Se siente enfermo o tiene fiebre hoy?)	○ YES(Si)	☒ NO

I state that the above history is true and complete to the best of my knowledge. I received the Vaccine Information Statement: "Influenza (Flu) Vaccine (Inactivated or Recombinant): What You Need To Know" CDC form number 42 U.S.C. (8/07/2015) §300aa-26 on ___/___/_____ and have been given the opportunity to ask questions.

(Afirmo que los antecedentes anteriores son verdaderos y completos a mi leal saber y entender. Recibí la Declaración de Información de la Vacuna: La influenza (gripe) vacunas Inactivadas o recombinante): Lo que usted necesita saber "CDC 42 U.S.C. (8/07/2015), Sección 300aa-26,el ___/___/____ y se me dio la oportunidad de hacer preguntas.)

☒ I understand the benefits and risks of influenza vaccine, and ask that the vaccine be given to me.
(Comprendo los beneficios y los riesgos de la vacuna contra la influenza y solicito que se me administre).
☐ I decline the influenza vaccine and understand the risk of doing so.
(Después de rechazar la vacuna contra el virus de la influenza y entender el riesgo de hacerlo.)

Patient Signature (Firma del paciente)	Date (Fecha)
[signature]	10/24/2016

INJECTION INFORMATION (INFORMACIÓN DE INYECCIÓN)

Vaccine:	Influenza Vaccine-afluria	Manufacturer:	Seqiru S
Lot Number:	138492 11A	Vaccine Expiration Date:	6/30/17
Site	☐ Right Deltoid ☒ Left Deltoid	Other:	

Administered by:	Title:	Date
Veronica Ferro, LPN	LPN	10/24/16

NA0662a
Issued 08/2013

Revised 8/2016

CORIZON HEALTH

Psychotropic Medication Consent Form

DEMOGRAPHICS

Facility Name:	ISCI	Inmate Number:	94691
Inmate Name:	Edmo, Mason	Date of Birth:	[redacted]
Location:	Unit 11e	Sex:	☑ Male ☐ Female

I, Edmo agree to treatment with the following

Remeron (mirtazapine)

I have been made aware that the following are benefits which may occur through taking these medications:

improved mood, energy, concentration, sleep, appetite, irritability, anxiety, excessive guilt, negative thinking

I have been made aware that possible side effects of taking these medications may be:

dizziness, fatigue, sedation, dry mouth, constipation, decreased white blood cell count, increased risk of suicidal ideation and behavior for 18-24 years olds during the first 2 months of treatment, weight gain
Please discuss use of this medication during pregnancy with your physician

I voluntarily agree to take the medication(s) listed above as prescribed by the psychiatric provider. I understand that this permission may be revoked at my discretion. I have had an opportunity to ask questions I wished to ask.

SIGNATURES

Provider's Signature	Date/Time: 11/27/16
X Inmate's Signature	Witness: PJCash RN Patricia Cash, RN

I have been advised to take the medication(s) listed above, but I am unwilling to take the medication as recommended. The possible consequences of not taking the medication have been explained to me. Specifically:

Provider's Signature	Date/Time
Inmate's Signature	Witness

BH7207

CONSENT FOR MENTAL HEALTH/SUBSTANCE ABUSE TREATMENT/EVALUATION

OFFENDER NAME (Last, First, MI):	IDOC #:
Edmo, Mason	94691

It is important that you understand the kinds of services you will be provided and the terms and conditions under which these services will be offered.

I, Edmo, Mason, am requesting the following from the staff of _____: (initial all that apply)

X Group Counseling X Secondary MH/SA Evaluation

As a condition of that treatment service, **I acknowledge, understand, and agree to the following terms:** (please initial each item)

X I am aware that the practice of psychology/psychiatry/social work/counseling/group counseling treatment is not an exact science. The program staff believes that the treatment strategies employed provide a useful intervention for mental health/substance use problems. I acknowledge that no guarantee can be made concerning the outcome of any evaluation or treatment that may be provided.

X I understand that evaluation and treatment will involve the discussion of personal information about my history that, at times, may be uncomfortable.

I agree to participate in the following: (please initial all that apply)

___ Adjustment to Prison	___ Grief and Loss	___ Living with Depression
___ PTSD	___ Release Process Group	___ Stress Mgmt./Relaxation
___ Emotional Regulation Training	___ Living with Co-occurring Disorder	___ Living with Schizophrenia
___ Mood Management	___ Living with Bipolar Disorder	X GD Process Living with OCD

Limitations on Confidentiality: (please initial each item)

I understand my rights of confidentiality apply to all communications with the therapist/counselor, subject to the limitations as described below:

I understand that, while mental health/substance abuse information is confidential, there are exceptions. A therapist is required to disclose confidential information without my consent under certain circumstances that include, but are not limited to, the following:

a) if it is determined that I pose a danger to myself or others or the security of the institution;
b) if I divulge information which would cause the therapist to develop a reasonable belief that I have abused or neglected a minor, and elderly or disabled person, or a member of another protected class; or
c) if I file a suit against the therapist for malpractice.

X I understand that, while every effort will be made to guard my confidentiality, because of the nature of group therapy, absolute confidentiality cannot be guaranteed.

Duration of Consent: (please initial each item)

X I am aware that I may withdraw my consent at any time with appropriate written notice. However, I agree that this authorization will remain in effect for the duration of all professional mental health/substance abuse services rendered, or until such authorization is revoked by me in writing.

X I agree that a photocopy of this form may be used in lieu of the original.

X I acknowledge that I have received a copy of the Consent for Mental Health/Substance Use Treatment, that I have read/had the information read to me and understand the information.

X I acknowledge I have received a copy of the group expectations and ground rules.

X I agree to abide by group expectations and ground rules and understand disciplinary action, as outlined in the handout, may be taken for violating said rules.

Edmo
OFFENDER SIGNATURE

12/22/15
DATE

CONSENT FOR MENTAL HEALTH/SUBSTANCE ABUSE TREATMENT/EVALUATION

OFFENDER NAME (Last, First, MI):	IDOC #:
Edmo, Mason	94691

It is important that you understand the kinds of services you will be provided and the terms and conditions under which these services will be offered.

I, Edmo, Mason, am requesting the following from the staff of _____: (initial all that apply)

AG Group Counseling AG Secondary MH/SA Evaluation

As a condition of that treatment service, **I acknowledge, understand, and agree to the following terms:** (please initial each item)

AG I am aware that the practice of psychology/psychiatry/social work/counseling/group counseling treatment is not an exact science. The program staff believes that the treatment strategies employed provide a useful intervention for mental health/substance use problems. I acknowledge that no guarantee can be made concerning the outcome of any evaluation or treatment that may be provided.

AG I understand that evaluation and treatment will involve the discussion of personal information about my history that, at times, may be uncomfortable.

I agree to participate in the following: (please initial all that apply)

__ Adjustment to Prison	__ Grief and Loss	__ Living with Depression
__ PTSD	__ Release Process Group	__ Stress Mgmt./Relaxation
__ Emotional Regulation Training	__ Living with Co-occurring Disorder	__ Living with Schizophrenia
__ Mood Management	__ Living with Bipolar Disorder	__ Living with OCD

Limitations on Confidentiality: (please initial each item)

I understand my rights of confidentiality apply to all communications with the therapist/counselor, subject to the limitations as described below:

I understand that, while mental health/substance abuse information is confidential, there are exceptions. A therapist is required to disclose confidential information without my consent under certain circumstances that include, but are not limited to, the following:
a) if it is determined that I pose a danger to myself or others or the security of the institution;
b) if I divulge information which would cause the therapist to develop a reasonable belief that I have abused or neglected a minor, and elderly or disabled person, or a member of another protected class; or
c) if I file a suit against the therapist for malpractice.

AG I understand that, while every effort will be made to guard my confidentiality, because of the nature of group therapy, absolute confidentiality cannot be guaranteed.

Duration of Consent: (please initial each item)

AG I am aware that I may withdraw my consent at any time with appropriate written notice. However, I agree that this authorization will remain in effect for the duration of all professional mental health/substance abuse services rendered, or until such authorization is revoked by me in writing.

AG I agree that a photocopy of this form may be used in lieu of the original.

AG I acknowledge that I have received a copy of the Consent for Mental Health/Substance Use Treatment, that I have read/had the information read to me and understand the information.

AG I acknowledge I have received a copy of the group expectations and ground rules.

AG I agree to abide by group expectations and ground rules and understand disciplinary action, as outlined in the handout, may be taken for violating said rules.

A. Edmo — 08-31-15

OFFENDER SIGNATURE — DATE

CONSENT FOR MENTAL HEALTH/SUBSTANCE ABUSE TREATMENT/EVALUATION

OFFENDER NAME (Last, First, MI):	IDOC #:
EDMO, MASON ADREE	94691

It is important that you understand the kinds of services you will be provided and the terms and conditions under which these services will be offered.

I, Adree Edmo, am requesting the following from the staff of IDOC / ISCI: (initial all that apply)

X Group Counseling ___ Secondary MH/SA Evaluation

As a condition of that treatment service, **I acknowledge, understand, and agree to the following terms:** (please initial each item)

AE I am aware that the practice of psychology/psychiatry/social work/counseling/group counseling treatment is not an exact science. The program staff believes that the treatment strategies employed provide a useful intervention for mental health/substance use problems. I acknowledge that no guarantee can be made concerning the outcome of any evaluation or treatment that may be provided.

AE I understand that evaluation and treatment will involve the discussion of personal information about my history that, at times, may be uncomfortable.

I agree to participate in the following: (please initial all that apply)

___ Adjustment to Prison	___ Grief and Loss	___ Living with Depression
X PTSD	___ Release Process Group	___ Stress Mgmt./Relaxation
___ Emotional Regulation	___ Living with Co-occurring Disorder	___ Living with Schizophrenia
___ Training	___ Living with Bipolar Disorder	___ Living with OCD
___ Mood Management		

Limitations on Confidentiality: (please initial each item)

I understand my rights of confidentiality apply to all communications with the therapist/counselor, subject to the limitations as described below:

I understand that, while mental health/substance abuse information is confidential, there are exceptions. A therapist is required to disclose confidential information without my consent under certain circumstances that include, but are not limited to, the following:

AE a) if it is determined that I pose a danger to myself or others or the security of the institution;
b) if I divulge information which would cause the therapist to develop a reasonable belief that I have abused or neglected a minor, and elderly or disabled person, or a member of another protected class; or
c) if I file a suit against the therapist for malpractice.

AE I understand that, while every effort will be made to guard my confidentiality, because of the nature of group therapy, absolute confidentiality cannot be guaranteed.

Duration of Consent: (please initial each item)

AE I am aware that I may withdraw my consent at any time with appropriate written notice. However, I agree that this authorization will remain in effect for the duration of all professional mental health/substance abuse services rendered, or until such authorization is revoked by me in writing.

AE I agree that a photocopy of this form may be used in lieu of the original.

AE I acknowledge that I have received a copy of the Consent for Mental Health/Substance Use Treatment, that I have read/had the information read to me and understand the information.

AE I acknowledge I have received a copy of the group expectations and ground rules.

AE I agree to abide by group expectations and ground rules and understand disciplinary action, as outlined in the handout, may be taken for violating said rules.

Adree Edmo — OFFENDER SIGNATURE

March 24, 2015 — DATE

CMS

CORRECTIONAL MEDICAL SERVICES
PSYCHOTROPIC MEDICATION CONSENT FORM

I, EDWARD MASON I.D. 94691, agree to treatment with the following medications in the dosage recommended to me by the psychiatrist:

Effexor (venlafaxine)

I have been made aware that the following are benefits which may occur through taking these medications:

improved mood, energy, concentration, sleep, appetite, irritability, anxiety, excessive guilt, negative thinking

I have been made aware that possible side-effects of taking these medications may be:

headache, anxiety, dizziness, fatigue, sedation, sexual dysfunction, nausea, increased risk of suicidal ideation and behavior for 18-24 years olds during the first 2 months of treatment

I voluntarily agree to take the medication(s) listed above as prescribed by the psychiatrist. I understand that this permission may be revoked at my discretion. I have had an opportunity to ask questions I wished to ask.

Jeremy Stoddart, MD
Physician's Signature

Inmate's Signature

Date 3/10/15

Witness Ellen Brewer, RN

I have been advised to take the medication(s) listed above, but I am unwilling to take the medication as recommended. The possible consequences of not taking the medication have been explained to me. Specifically:

_____

_____

_____

Physician's Signature

Inmate's Signature

CMS 7168 REV. 09/01/04

CORIZON HEALTH

Influenza Campaign 2015-16
Patient
Consent or Refusal for Vaccine

DEMOGRAPHICS			
Facility	ISCI		Inmate Number 94691
Inmate Name	Edmo		Date of Birth [redacted]
Housing Location	● General Population	○ Segregation	Sex: ☒ Male ☐ Female
	○ Infirmary	○ Other	

HISTORY

1.	Have you had a flu shot before? (¿Le han aplicado una inyección contra la influenza anteriormente?)	☒ YES(Sí)	○ NO
	If you answer yes to any of the following questions, we will not administer a flu shot. (Si responde "sí" a alguna de las siguientes preguntas, no le administraremos la inyección contra la influenza.)		
2.	Have you ever had a severe allergic reaction to a flu shot? Guillian-Barre Syndrome (GBS)? (¿Alguna vez ha tenido una reacción alérgica grave a una inyección contra la influenza?)	○ YES(Sí)	☒ NO
3.	Do you have a severe egg allergy? (¿Es alérgico al huevo?)	○ YES(Sí)	☒ NO
4.	Have you ever had an allergic reaction to any vaccine? (¿Ha tenido alguna reacción alérgica a alguna vacuna?)	○ YES(Sí)	☒ NO
	*If you answer yes to any of the following questions, we will not administer a flu shot **TODAY**. (Si responde "sí" a alguna de las siguientes preguntas, no le administraremos la inyección contra la influenza **HOY**.)*		
5.	Are you currently taking an antibiotic for infection? (¿Actualmente está tomando algún antibiótico para una infección?)	○ YES(Sí)	☒ NO
6.	Do you feel ill today or do you have a fever? (¿Se siente enfermo o tiene fiebre hoy?)	○ YES(Sí)	☒ NO

I state that the above history is true and complete to the best of my knowledge. I received the Vaccine Information Statement: "Influenza (Flu) Vaccine (Inactivated or Recombinant): What You Need To Know" CDC form number 42 U.S.C. (8/07/2015) §300aa-26 on 10/21/15 and have been given the opportunity to ask questions.

(Afirmo que los antecedentes anteriores son verdaderos y completos a mi leal saber y entender. Recibí la Declaración de Información de la Vacuna: La influenza (gripe) vacunas inactivadas o recombinante): Lo que usted necesita saber "CDC 42 U.S.C. (8/07/2015), Sección 300aa-26,el ___/___/____ y se me dio la oportunidad de hacer preguntas.)

☒ I understand the benefits and risks of influenza vaccine, and ask that the vaccine be given to me.
(Comprendo los beneficios y los riesgos de la vacuna contra la influenza y solicito que se me administre).
☐ I decline the influenza vaccine and understand the risk of doing so.
(Después de rechazar la vacuna contra el virus de la influenza y entender el riesgo de hacerlo.)

C. Edmo — 10/21/2015

Patient Signature(Firma del paciente) — Date (Fecha)

INJECTION INFORMATION (INFORMACIÓN DE INYECCIÓN)

Vaccine:	Influenza	Manufacturer:	Novartis
Lot Number:	1514901	Vaccine Expiration Date:	05/2016
Site	☒ Right Deltoid ☐ Left Deltoid	Other:	
Administered by:	W. Wingert RN DON / Will Wingert RN/DON	Title:	Date: 10/21/15

Flu vac Novartis Lot 1514901 Expires 05/2016
Given 10/21/15 Right Deltoid
William J Wingert, RN DON

NA0662a
Issued 08/20

CORIZON
Promote a culture of safety

Food Employee Illness and Lesion Reporting Agreement Idaho DOC

Preventing transmission of diseases through food by infected food employees with emphasis on illness due to Salmonella Shigella spp., Shiga toxin-producing Escherichia coli, hepatitis A virus, or Norovirus

The purpose of the agreement is to ensure that Food Employees notify the *Person in Charge* when they experience any of the conditions listed so that the *Person in Charge* can take appropriate steps to preclude the transmission of food borne illness.

I AGREE TO REPORT ANY OF THE FOLLOWING TO THE PERSON IN CHARGE:

Future Symptoms and Pustular Lesions:

1. Diarrhea
2. Fever
3. Vomiting
4. Jaundice
5. Sore throat with fever
6. Lesion containing pus on the hand, wrist, or an exposed body part (such as boils and infected wounds, however small)

Future Medical Diagnosis:

Whenever diagnosed as being ill with typhoid fever *(Salmonella typhi)*, shigellosis *(Shigella* spp.), Shiga toxin-producing *Escherichia coli* infection *(Escherichia coli)* 157:H7), hepatitis A (hepatitis A virus), or Norovirus.

Future High-Risk Conditions:

1. Exposure to or suspicion of causing any confirmed outbreak of typhoid fever, shigellosis, Shiga toxin-producing *Escherichia coli* infection, hepatitis A, or Norovirus.
2. A household member diagnosed with typhoid fever, shigellosis, and illness due to Shiga toxin-producing Escherichia *coli*, hepatitis A, or Norovirus.
3. A household member attending or working in a setting experiencing a confirmed outbreak of typhoid fever, shigellosis, Shiga toxin-producing *Escherichia coli* infection, hepatitis A, or Norovirus.

I have read (or had explained to me) and understand the requirements concerning my responsibilities under the Food Code and this agreement to comply with:

1. Reporting requirements specified above involving symptoms, diagnoses, and high-risk conditions specified;
2. Work restrictions or exclusions that are imposed upon me; and
3. Good hygienic practices.

I understand that failure to comply with the terms of this agreement could lead to action by the food establishment or the food regulatory authority that may jeopardize my employment and may involve legal action against me.

Applicant or Food Employee Name (please print) ANDREE DMO

Signature of Applicant or Food employee Andree Edmo IDOC# 94691 DOB [redacted]

Medical Clearance- Food Service Workers

Offenders printed name Andree Edmo / Mason Edmo

☑ Offender is medically cleared for Food Service work.
☐ Offender is **not** cleared for Food Service work

Medical Authorities Signature W. Wingert RN BSN Date 10/14/15 Location Corizon @ ISCI 13500 S. Pleasant Valley Rd. Kuna, Idaho 83634

Will Wingert, RN BSN

This document is to be reviewed with the offender, signed, witnessed, filed in the medical record and a copy sent to the facility food service.
This form shall be completed for all offenders in RDU and the annually during their birth month.

RECEIVED
OCT 11 2012

Pharma Corr (OKC)

10-04-12

My name is Mason Edmo and I am a transgender female currently incarcerated at Idaho State Correctional Institution here in Boise, ID.

I am writing in concern to the medication I am receiving, a treatment for gender Identity Disphoria;

Rx # 26491788 Dr. C. Whinnery

- Spironolactone 25 mg tabs Eqv tildactone
- Aspirin EC81 mg TB EC Eqv. Ecotrin (ASA-EC)
- Calcium carb 1250 mg / Vitamin D 1250 mg T.

I am hoping your pharmacy could tell me exactly what these medications are used to treat, as well as the described Equivalents I'd appreciate any information you could give me.

Sincerely,

Mason Edmo

Mason Edmo #94691
ISCI 110-A 103A
P.O. BOX 14
Boise, ID 83707

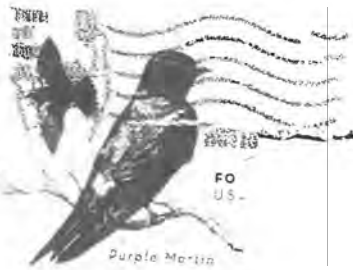
Will discuss at CCC appt Nov 2012

11/15/12

Cathy Whinnery, M.D.

Inmate Name
Inmate No. housing
IDAHO DEPARTMENT OF CORRECTIONS
Institution
Address P.O. Box
City State Zip
INMATE CORRESPONDENCE

BOISE ID 836
09 OCT 2012 PM 3 L



RECEIVED
NOV 06 2012
LEGAL DEPT

Pharma Corr (OKC)
6705 Camille Ave.
Oklahoma City, OK 73149

rec'd
11-12-12
@

7814933202

SAINT ALPHONSUS REGIONAL MEDIC CENTER
Boise, ID 83706-

A Member of Trinity Health
Livonia, Michigan

Patient Name:	EDMO, MASC)
MRN:	(BIS)-002239563
Date of Birth:	[redacted]
Admit Date:	12/31/2016
Discharge Date:	12/31/2016
Account Number:	045365555-6366
Patient Type:	Emergency
Attending:	Campbell MD,Matthew Brent

ED Physician Note

DOCUMENT NAME: ED Physician Notes
ELECTRONICALLY SIGNED BY: Campbell MD,Matthew Brent (1/1/2017 01:12 MST)

Male GU complaint

Patient: **EDMO, MASON D** **MRN: (BIS)-002239563** **FIN: 045365555-6366**
Age: **29 years** Sex: **Male** DOB: [redacted]
Associated Diagnoses: **None**
Author: **Campbell MD, Matthew Brent**

Basic Information
Time seen: Date & time 12/31/2016 18:47:00.
History source: Patient, police.
Arrival mode: Police.
History limitation: None.
Seen at St. Als main, Boise

History of Present Illness
The patient presents for a genitourinary problem and Patient attempted to self remove right testicle. Patient in jail has body dysmorphic disorder.. The onset was 2 hours ago. The course/duration of symptoms is constant. Location: Right scrotum. The degree of symptoms is severe. The exacerbating factor is movement. The relieving factor is none. Risk factors consist of none. Prior episodes: none. Therapy today: none. Associated symptoms: abdominal pain. Additional history: sexual history: non-contributory.

Review of Systems
Constitutional symptoms: No fever,
Skin symptoms: No rash,
Eye symptoms: No recent vision problems, no blurred vision.
ENMT symptoms: No sore throat, no nasal congestion.
Respiratory symptoms: No shortness of breath, no wheezing.
Cardiovascular symptoms: No chest pain, no syncope.
Gastrointestinal symptoms: No abdominal pain, no nausea, no vomiting, no diarrhea.
Genitourinary symptoms: Testicular pain.
Musculoskeletal symptoms: No back pain, no Muscle pain.
Neurologic symptoms: No headache,
Psychiatric symptoms: Anxiety, depression.
Hematologic/Lymphatic symptoms: Bleeding tendency negative, bruising tendency negative.
Additional review of systems information: All other systems reviewed and otherwise negative.

Health Status
Immunizations: Up to date.

Past Medical/ Family/ Social History

Printed Date/Time: 1/6/2017 11:45 EST
Report Request ID: 99823847

Tripper Povar, NP-C

1/13/17

SAINT ALPHONSUS REGIONAL MEDI[illegible] CENTER
Boise, ID 83706-

A Member of Trinity Health
Livonia, Michigan

Patient Name:	EDMO, MAS D
MRN:	(BIS)-00223956:
Date of Birth:	[redacted]
Admit Date:	12/31/2016
Discharge Date:	12/31/2016
Account Number:	045365555-6366
Patient Type:	Emergency
Attending:	Campbell MD,Matthew Brent

ED Physician Note

Medical history

Transgender body dysmorphic disorder.
Social history: Tobacco use: Denies.

Physical Examination

Vital Signs
Vital Signs/Measurements

12/31/2016 20:00 MST	Temperature	98.5 Degrees F NML
	Pulse Rate	**102 BPM HI**
	Pulse Oximetry	98 % NML
	Systolic BP	132 mmHg NML
	Diastolic BP	83 mmHg NML
	MAP-CF	94

General: Alert, moderate distress, anxious.
Skin: Warm.
Head: Atraumatic.
Neck: Supple.
Eye: Pupils are equal, round and reactive to light.
Ears, nose, mouth and throat: Oral mucosa moist.
Respiratory: Respirations are non-labored.
Chest wall: No deformity.
Back: Nontender.
Musculoskeletal: Normal ROM, normal strength, no tenderness, no swelling.
Gastrointestinal: Soft, Tenderness: Moderate, suprapubic, Guarding: Negative, Rebound: Negative, Bowel sounds: Normal.
Genitourinary: Testes: Right, severe, tenderness, Right lateral aspect of scrotum with approximately 4 cm linear deep laceration with exposed testicle on the exterior of the scrotum very minimal bleeding.
Examination with Doppler revealed positive blood flow severe tenderness however..
Neurological: Alert and oriented to person, place, time, and situation, No focal neurological deficit observed, CN II-XII intact, normal sensory observed, normal motor observed, normal speech observed, normal coordination observed.
Lymphatics: No lymphadenopathy.
Psychiatric: Cooperative.

Medical Decision Making

Rationale: Dr. King from urology was consult at and evaluated patient in the ER and provided the surgical procedure in the emergency department while I provided conscious sedation please see procedure notes from Dr.king for the repair procedure and my note for sedation..
Results review: Lab results : LAB

SAINT ALPHONSUS REGIONAL [illegible] CENTER
Boise, ID 83706-

A Member of Trinity Health
Livonia, Michigan

Patient Name:	EDMC [illegible] AS [illegible]
MRN:	(BIS)-002239563
Date of Birth:	[redacted]
Admit Date:	12/31/2016
Discharge Date:	12/31/2016
Account Number:	045365555-6366
Patient Type:	Emergency
Attending:	Campbell MD,Matthew Brent

ED Physician Note

12/31/2016 18:59 MST	Blood Type ABO and Rh(D)	O POSITIVE
	Antibody Screen	NEGATIVE
	Crossmatch Expiration	01/03/2017
	Blood Component Type	RED CELL GROUP
	Arm Band Number	PFC7841
	Phlebotomist	576
12/31/2016 18:56 MST	**Sodium Level**	**130 mEq/L LOW**
	Potassium Level	**3.4 mEq/L LOW**
	Chloride Level	102 mEq/L
	Carbon Dioxide Level	**19 mEq/L LOW**
	Anion Gap	12 mEq/L
	Glucose Level	**107 mg/dL HI**
	BUN	12 mg/dL
	Creatinine	0.73 mg/dL
	Est CrCl IBW (mL/min)-RX	148.80 mL/min
	GFR Estimated Non African American	135.0 mL/min/1.73 m2
	GFR Estimated African American	163.4 mL/min/1.73 m2
	Calculated GFR	>60 mL/min/1.73 m2
	Comment GFR	*NOT VALUED*
	Calcium Total	**8.0 mg/dL LOW**
	Total Protein	6.5 gm/dL
	Alkaline Phosphatase	44 Units/L
	ALT/SGPT	13 Units/L
	AST/SGOT	15 Units/L
	Bilirubin Total	0.6 mg/dL
	Albumin Level	3.7 gm/dL
	Globulin Level	2.8 gm/dL
	WBC Count	7.29 thou/cumm
	Red Blood Cell Count	4.20 million/mm3
	Hemoglobin	13.4 gm/dL
	Hematocrit	**38.0 % LOW**
	MCV	91 FL
	MCH	31.9 Picograms
	MCHC	35.3 gm/dL
	RDW	11.8 %
	Platelet Count	216 thou/cumm
	MPV	8.7 FL
	Diff Method	AUTO DIFF
	Neutrophil Percent	76.0 %
	Lymphocyte Percent	15.2 %
	Monocyte Percent	7.5 %

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Report Request ID: 99823847

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Boise, ID 83706-

A Member of Trinity Health
Livonia, Michigan

Patient Name:	EDMC, AS L
MRN:	(BIS)-002239563
Date of Birth:	[redacted]
Admit Date:	12/31/2016
Discharge Date:	12/31/2016
Account Number:	045365666-6366
Patient Type:	Emergency
Attending:	Campbell MD,Matthew Brent

ED Physician Note

Eosinophil Percent	0.7 %
Basophil Percent	0.5 %
Immature Granulocyte Percent	0.1 %
Nucleated RBC Percent	0.0
Nucleated RBC	0.00
Neutrophil Absolute	5.53 thou/cumm
Lymphocyte Absolute	1.11 thou/cumm
Monocyte Absolute	0.55 thou/cumm
Eosinophil Absolute	0.05 thou/cumm
Basophil Absolute	0.04 thou/cumm
Immature Granulocyte Absolute	0.01 thou/cumm
Prothrombin Time (PT)	12.1 Sec
INR	1.03

Procedure

Procedural sedation

Time: 12/31/2016 21:27:00 .
Confirmed: Patient and procedure correct.
Consent: Patient, Has signed consent.
Indication: Laceration repair.
Monitoring: Cardiac, blood pressure, continuous pulse oximetry.
Preparation: Suction, IV access, Constant attendance, Supplemental oxygen.
ASA Class: 2- mild systemic disease.
Physical exam: See physical exam documentation.
Pre sedation vital signs: See nurse's notes.
Post sedation vital signs: See nurse's notes.
Procedure Time: See hospital procedure form, time 21min.
Post sedation condition: Improved.
Patient tolerated: Well.
Complications: None.
Performed by: Self.

Impresaion and Plan

Diagnosis

Testicular injury (ICD10-CM S39.94XA, Discharge, Medical)
Scrotal laceration (ICD10-CM S31.31XA, Discharge, Medical)

Plan

Condition: Improved, Stable.
Disposition: Discharged: to police.
Prescriptions: Med Rec/RX
Pharmacy:

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Boise, ID 83706-

A Member of Trinity Health
Livonia, Michigan

Patient Name:	EDMC[illegible]AL[illegible]D
MRN:	(BIS)-002239563
Date of Birth:	[redacted]
Admit Date:	12/31/2016
Discharge Date:	12/31/2016
Account Number:	045365555-8366
Patient Type:	Emergency
Attending:	Campbell MD,Matthew Brent

ED Physician Note

Norco 10 mg-325 mg oral tablet (Prescribe): 1 Tab, PO, Q4h, for 3 Day(s), (not to exceed 4000 mg acetaminophen per day), PRN: for pain, 20 Tab, 0 Refill(s)
Motrin 600 mg oral tablet (Prescribe): 1 Tab, PO, TID, for 5 Day(s), PRN: pain, 15 Tab, 0 Refill(s)
Augmentin 875 mg-125 mg oral tablet (Prescribe): 1 Tab, PO, Q12h, for 5 Day(s), 10 Tab, 0 Refill(s).

Patient was given the following educational materials: Laceration Care, Adult, Easy-to-Read, Sutured Wound Care, Easy-to-Read, Sutured Wound Care, Easy-to-Read, Laceration Care, Adult, Easy-to-Read, Sutured Wound Care, Easy-to-Read, Laceration Care, Adult, Easy-to-Read.

Follow up with: Prison clinician In 3 days 1/3/2017 Please have medical provider remove the drain by removing the suture that is at the most distal aspect of the laceration that is sewed through the drain itself which is the last suture in the laceration all other sutures will be absorbable. This is to be removed in 2-3 days after placement. Continue by mouth anabiotic's and pain medications as needed as prescribed. If there is questions regarding wound care or other concerns regarding the procedure please contact Dr. Dawn King at the number below provided for follow-up referral.; PCP Unknown Physician, Family Practice, Pediatrics Within Follow-up as needed; Dawn King, Urology Within Follow-up as needed, only if needed Please contact her questions regarding wound management.

Counseled: Patient, Regarding diagnosis, Regarding diagnostic results, Regarding treatment plan, Regarding prescription, Patient indicated understanding of instructions.

SAINT ALPHONSUS REGIONAL [illegible] CENTER
Boise, ID 83706-

A Member of Trinity Health
Livonia, Michigan

Patient Name:	EDMO[illegible]A[illegible]D
MRN:	(BIS)-002239563
Date of Birth:	[redacted]
Admit Date:	12/31/2016
Discharge Date:	12/31/2016
Account Number:	045365555-6366
Patient Type:	Emergency
Attending:	Campbell MD,Matthew Brent

Operative/Procedure Report

DOCUMENT NAME: Operative/Procedure Report
ELECTRONICALLY SIGNED BY: King MD,Dawn K (1/2/2017 11:31 MST)

Operative Report

DATE OF PROCEDURE:
12/31/2016.

PREOPERATIVE DIAGNOSIS:
Scrotal laceration.

POSTOPERATIVE DIAGNOSIS:
Scrotal laceration.

OPERATION PERFORMED:
Scrotal exploration, repositioning of right testis and closure of scrotal laceration.

SURGEON:
Dawn K. King, MD.

ANESTHETIC:
Local plus IV sedation in the Emergency Room.

HISTORY:
This patient is a 29-year-old male who currently resides at the Idaho Correctional Facility. He performs self-mutilation this evening and sustained a right hemiscrotal laceration. The patient then was able to place traction on the testes and this was pulled out through the wound. The patient states he did not twist his testes and then was in pain and was brought to the Emergency Room. He has apparently attempted self-mutilation in the past and is a transgender individual. Apparently this patient is receiving hormonal therapy for his transgender issues. He has not been to this facility before as far as we know.

DESCRIPTION OF PROCEDURE:
The patient was in the Emergency Room, the wound was evaluated. He had an exposed right testis with the tunica intact. There was some mild trauma to the tissue, but a Doppler ultrasound confirmed that there was blood flow to the testis. The patient was given IV sedation, full sedation with the Emergency Room physician in attendance. Once the patient was sedated, the wound was then prepped with copious amounts of Betadine. The testis was inspected. A small amount of traumatized tissue was trimmed. There was some minimal amount of bleeding from the wound. I explored the cord. There did not appear to be torsion. The testis was replaced back into the right hemiscrotum and the wound was irrigated with saline. The incision was then closed with interrupted sutures of 3-0 chromic. I did leave a small Penrose drain in the lateral aspect of the wound. This was sutured to the skin with a 3-0 chromic. Antibiotic-laden fluff gauze was applied, followed by mesh underwear. The patient tolerated the procedure well. He will be discharged back to the prison on oral antibiotics. The Penrose drain can be removed in about 2 days. The sutures will absorb and the patient can follow up with a physician at the prison or can follow up in our Urology Clinic as needed.

SAINT ALPHONSUS REGIONAL D L CENTER
Boise, ID 83706-

A Member of Trinity Health
Livonia, Michigan

Patient Name:	EDMC, A D
MRN:	(BIS)-002239583
Date of Birth:	[redacted]
Admit Date:	12/31/2016
Discharge Date:	12/31/2016
Account Number:	045365555-6366
Patient Type:	Emergency
Attending:	Campbell MD,Matthew Brent

Operative/Procedure Report

DAWN K KING, MD*
DKK:NTS
D: 12/31/2016 21:28:54
T: 12/31/2016 21:57:27
J: 378971
T: 6807497
DOS: 12/31/2016 EMPI: 6468139
PCP: PCP UNKNOWN PHYSICIAN
cc:

Printed Date/Time: 1/6/2017 11:45 EST
Report Request ID: 96823847

SAINT ALPHONSUS REGIONAL . . CENTER
Boise, ID 83706-

A Member of Trinity Health
Livonia, Michigan

Patient Name:	EDMO, [illegible] D
MRN:	(BIS)-002239563
Date of Birth:	[redacted]
Admit Date:	12/31/2016
Discharge Date:	12/31/2016
Account Number:	045365555-6368
Patient Type:	Emergency
Attending:	Campbell MD,Matthew Brent

Chemistry

General Chemistry

Procedure	Result	Reference Range	Units	Collected Date/Time	Performed Date/Time
Est CrCl IBW (mL/min)-RX	148.80 R1		mL/min	12/31/2016 18:56 MST	12/31/2016 21:15 EST
GFR Estimated Non African American	135.0		mL/min/1.73 m2	12/31/2016 18:56 MST	12/31/2016 21:15 EST
GFR Estimated African American	163.4		mL/min/1.73 m2	12/31/2016 18:56 MST	12/31/2016 21:15 EST
Sodium Level	130 L	[135-145]	mEq/L	12/31/2016 18:56 MST	12/31/2016 18:59 MST
Potassium Level	3.4 L	[3.6-5.0]	mEq/L	12/31/2016 18:56 MST	12/31/2016 18:59 MST
Chloride Level	102	[98-109]	mEq/L	12/31/2016 18:56 MST	12/31/2016 18:59 MST
Carbon Dioxide Level	19 L	[22-31]	mEq/L	12/31/2016 18:56 MST	12/31/2016 18:59 MST
Anion Gap	12	[6-16]	mEq/L	12/31/2016 18:56 MST	12/31/2016 18:59 MST
Glucose Level	107 H	[65-99]	mg/dL	12/31/2016 18:56 MST	12/31/2016 18:59 MST
BUN	12	[7-23]	mg/dL	12/31/2016 18:56 MST	12/31/2016 18:59 MST
Creatinine	0.73	[0.6-1.6]	mg/dL	12/31/2016 18:56 MST	12/31/2016 18:59 MST
Calculated GFR	>60	[>60]	mL/min/1.73 m2	12/31/2016 18:56 MST	12/31/2016 18:59 MST
Comment GFR	**NOT VALUED** R2			12/31/2016 18:56 MST	12/31/2016 18:59 MST
Calcium Total	8.0 L	[8.5-10.5]	mg/dL	12/31/2016 18:56 MST	12/31/2016 18:59 MST
Total Protein	6.5	[6.3-8.0]	gm/dL	12/31/2016 18:56 MST	12/31/2016 18:59 MST
Alkaline Phosphatase	44	[38-110]	Units/L	12/31/2016 18:56 MST	12/31/2016 18:59 MST
ALT/SGPT	13	[10-65]	Units/L	12/31/2016 18:56 MST	12/31/2016 18:59 MST
AST/SGOT	15	[10-45]	Units/L	12/31/2016 18:56 MST	12/31/2016 18:59 MST
Bilirubin Total	0.6 R3	[0.1-1.5]	mg/dL	12/31/2016 18:56 MST	12/31/2016 18:59 MST
Albumin Level	3.7	[3.5-5.0]	gm/dL	12/31/2016 18:56 MST	12/31/2016 18:59 MST

Printed Date/Time: 1/6/2017 11:45 EST
Report Request ID: 99823847

SAINT ALPHONSUS REGIONAL [illegible] CENTER
Boise, ID 83706-

A Member of Trinity Health
Livonia, Michigan

Patient Name:	EDMC, AS
MRN:	(BIS)-002239563
Date of Birth:	[redacted]
Admit Date:	12/31/2016
Discharge Date:	12/31/2016
Account Number:	045365555-6366
Patient Type:	Emergency
Attending:	Campbell MD,Matthew Brent

Chemistry

General Chemistry

Procedure	Result	Reference Range	Units	Collected Date/Time	Performed Date/Time
Globulin Level	2.8	[2.0-4.0]	gm/dL	12/31/2016 18:56 MST	12/31/2016 18:59 MST

Result Comments

R1: Est CrCl IBW (mL/min)-RX
Height = 175 cm
Weight= 80 kg
IBW = 70.46 kg
Creatinine = 0.73 mg/dL

Estimated Creatinine Clearance (ml/min)
Cockcroft Gault equation:
CrCl = (140 - age) x IBW / (Scr x 72) (x 0.85 for females)
Estimate ideal body weight in (kg)
Males: IBW = 50 kg + 2.3 kg for each inch over 5 feet.
Females: IBW = 45.5 kg + 2.3 kg for each inch over 5 feet.

If actual weight is < IBW, use the actual weight.
If CrCl <=0, show "Missing Data".
This CrCl is only calculated when Creatinine result is saved, and Height and Weight information is available. Not on Weight or Height change.
Children < 2 years old will not show Est CrCl.

R2: Comment GFR
Reference ranges for estimated GFR:
Less than 60 mL/min/1.73m2 indicates chronic kidney disease if found over a 3 month period. Less than 15 mL/min/1.73m2 indicates kidney failure.
For African Americans, multiply the estimated GFR by 1.21.
The MDRD equation is most valid for patients with some degree of renal impairment. The MDRD equation is not valid for patients under 20 years of age.

Creatinine results have been standardized to be traceable to the IDMS method in response to the NKDEP initiative.

R3: Bilirubin Total
A metabolite of Naproxen has been shown to interfere with this method of measuring total bilirubin and patients who have taken Naproxen may show a spurious elevation in total bilirubin levels.

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Report Request ID: 99823847

SAINT ALPHONSUS REGIONAL [illegible] CENTER
Boise, ID 83706-

A Member of Trinity Health
Livonia, Michigan

Patient Name: EDMO, [illegible] D
MRN: (BIS)-002239563
Date of Birth: [redacted]
Admit Date: 12/31/2016
Discharge Date: 12/31/2016
Account Number: 045365555-6366
Patient Type: Emergency
Attending: Campbell MD,Matthew Brent

Hematology

CBC

Procedure	Result	Reference Range	Units	Collected Date/Time	Performed Date/Time
WBC Count	7.29	[4.60-12.40]	thou/cumm	12/31/2016 18:56 MST	12/31/2016 18:59 MST
Red Blood Cell Count	4.20	[3.92-5.72]	million/mm3	12/31/2016 18:56 MST	12/31/2016 18:59 MST
Hemoglobin	13.4	[13.2-17.6]	gm/dL	12/31/2016 18:56 MST	12/31/2016 18:59 MST
Hematocrit	38.0 L	[38.8-51.1]	%	12/31/2016 18:56 MST	12/31/2016 18:59 MST
MCV	91	[81.1-99.9]	FL	12/31/2016 18:56 MST	12/31/2016 18:59 MST
MCH	31.9	[25.1-34.6]	Picograms	12/31/2016 18:56 MST	12/31/2016 18:59 MST
MCHC	35.3	[30.2-35.7]	gm/dL	12/31/2016 18:56 MST	12/31/2016 18:59 MST
RDW	11.8	[11.5-16.9]	%	12/31/2016 18:56 MST	12/31/2016 18:59 MST
Platelet Count	216	[132.3-423.7]	thou/cumm	12/31/2016 18:56 MST	12/31/2016 18:59 MST
MPV	8.7	[8.7-12.7]	FL	12/31/2016 18:56 MST	12/31/2016 18:59 MST

Differential

Procedure	Result	Reference Range	Units	Collected Date/Time	Performed Date/Time
Diff Method	AUTO DIFF			12/31/2016 18:56 MST	12/31/2016 18:59 MST
Neutrophil Percent	76.0	[41.2-79.0]	%	12/31/2016 18:56 MST	12/31/2016 18:59 MST
Lymphocyte Percent	15.2	[11.5-47.9]	%	12/31/2016 18:56 MST	12/31/2016 18:59 MST
Monocyte Percent	7.5	[3.9-12.4]	%	12/31/2016 18:56 MST	12/31/2016 18:59 MST
Eosinophil Percent	0.7	[0.0-8.6]	%	12/31/2016 18:56 MST	12/31/2016 18:59 MST
Basophil Percent	0.5	[0.2-1.4]	%	12/31/2016 18:56 MST	12/31/2016 18:59 MST
Immature Granulocyte Percent	0.1 R1	[0.0-0.4]	%	12/31/2016 18:56 MST	12/31/2016 18:59 MST
Nucleated RBC Percent	0.0	[0-0.2]		12/31/2016 18:56 MST	12/31/2016 18:59 MST

Printed Date/Time: 1/6/2017 11:45 EST
Report Request ID: 99823847

SAINT ALPHONSUS REGIONAL [illegible] CENTER
Boise, ID 83706-

A Member of Trinity Health
Livonia, Michigan

Patient Name:	EDMO, [illegible] D
MRN:	(BIS)-002239563
Date of Birth:	[redacted]
Admit Date:	12/31/2016
Discharge Date:	12/31/2016
Account Number:	045366555-6366
Patient Type:	Emergency
Attending:	Campbell MD,Matthew Brent

Hematology

Differential

Procedure	Result	Reference Range	Units	Collected Date/Time	Performed Date/Time
Nucleated RBC	0.00	[0-0.012]		12/31/2016 18:56 MST	12/31/2016 18:59 MST
Neutrophil Absolute	5.53	[1.61-11.05]	thou/cumm	12/31/2016 18:56 MST	12/31/2016 18:59 MST
Lymphocyte Absolute	1.11	[0.80-3.98]	thou/cumm	12/31/2016 18:56 MST	12/31/2016 18:59 MST
Monocyte Absolute	0.55	[0.32-1.04]	thou/cumm	12/31/2016 18:56 MST	12/31/2016 18:59 MST
Eosinophil Absolute	0.05	[0.02-0.55]	thou/cumm	12/31/2016 18:56 MST	12/31/2016 18:59 MST
Basophil Absolute	0.04	[0.01-0.09]	thou/cumm	12/31/2016 18:56 MST	12/31/2016 18:59 MST
Immature Granulocyte Absolute	0.01 R2	[0.0-0.3]	thou/cumm	12/31/2016 18:56 MST	12/31/2016 18:59 MST

Result Comments

R1: Immature Granulocyte Percent
IG is composed of promyelocytes, metamyelocytes, myelocytes.

R2: Immature Granulocyte Absolute
An absolute IG result >0.1x103/uL is suggestive of a left shift. An absolute IG result >0.5x103/uL is suggestive of infection.

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Report Request ID: 99823847

SAINT ALPHONSUS REGIONAL [illegible] CENTER
Boise, ID 83706-

A Member of Trinity Health
Livonia, Michigan

Patient Name:	EDMC, ...AS ...D
MRN:	(BIS)-002239563
Date of Birth:	[redacted]
Admit Date:	12/31/2016
Discharge Date:	12/31/2016
Account Number:	045365555-6366
Patient Type:	Emergency
Attending:	Campbell MD,Matthew Brent

Coagulation

Coagulation - Routine

Procedure	Result	Reference Range	Units	Collected Date/Time	Performed Date/Time
Prothrombin Time (PT)	12.1	[9.5-12.8]	Sec	12/31/2016 18:56 MST	12/31/2016 18:59 MST
INR	1.03 R1			12/31/2016 18:56 MST	12/31/2016 18:59 MST

Result Comments
R1: INR
INR Therapeutic Ranges: 2.0-3.0 Standard Therapy 2.5-3.5 Intensive Therapy

Printed Date/Time: 1/6/2017 11:45 EST
Report Request ID: 99823847

SAINT ALPHONSUS REGIONAL ... CENTER
Boise, ID 83706-

A Member of Trinity Health
Livonia, Michigan

Patient Name:	EDMO, ...AS
MRN:	(BIS)-002239563
Date of Birth:	[redacted]
Admit Date:	12/31/2016
Discharge Date:	12/31/2016
Account Number:	045365555-6366
Patient Type:	Emergency
Attending:	Campbell MD,Matthew Brent

Blood Bank

Procedure	Result	Reference Range	Units	Collected Date/Time	Performed Date/Time
Blood Type ABO and Rh(D)	O POSITIVE			12/31/2016 18:59 MST	12/31/2016 19:05 MST
Antibody Screen	NEGATIVE	[NEG]		12/31/2016 18:59 MST	12/31/2016 19:05 MST
Crossmatch Expiration	01/03/2017			12/31/2016 18:59 MST	12/31/2016 19:05 MST
Blood Component Type	RED CELL GROUP			12/31/2016 18:59 MST	12/31/2016 19:05 MST
Arm Band Number	PFC7841			12/31/2016 18:59 MST	12/31/2016 19:05 MST
Phlebotomist	576			12/31/2016 18:59 MST	12/31/2016 19:05 MST

Printed Date/Time: 1/6/2017 11:45 EST
Report Request ID: 99823847

Saint Alphonsus Regional Medical Center

1055 N Curtis Road
Boise, ID 83706
(208) 367-2121
Emergency Room: (208) 367-3221

Patient Name: EDMO, MASON D

Birthdate: [redacted] Age: 29 Years Sex: Male MRN: (BIS)-002239563

Allergies: **No Known Medication Allergies**

Pharmacist please note--Allergy list may be incomplete.

Patient Address: PO BOX 14
BOISE, ID 83707-0014
Primary Health Plan: CORIZON (159)
Secondary Health Plan:
Third Health Plan:

Home Phone: (208) 000-0000
Work Phone:
Policy/Group #94691/
Policy/Group #:
Policy/Group #:

NEW Prescription(s)

Rx: Norco 10 mg-325 mg oral tablet

Start Date: **12/31/2016**
Order ID# 12061953297

SIG: **1 Tab PO Q4h for 3 Day(s) PRN for pain**
Dispense/Supply: **<20 (Twenty) Tab>**
Refill: **<No Refills>**
Instructions: **(not to exceed 4000 mg acetaminophen per day)**

VOID

DISPENSE AS WRITTEN **SUBSTITUTION PERMITTED**

Prescribed by: **Matthew Brent Campbell, MD**

Matthew Brent Campbell, MD
1055 N Curtis Rd
Boise, ID 83706
208.367.2121
Fax: 208.367.3564
Date: 12/31/2016
DEA #: FC1125524
NPI#: 1790981025

Rx Not Valid Unless Signed By Prescriber OR Transmitted Electronically

Saint Alphonsus Regional Medical Center

1055 N Curtis Road
Boise, ID 83706
(208) 367-2121
Emergency Room: (208) 367-3221

Patient Name: EDMO, MASON D

Birthdate [redacted] Age: 29 Years Sex: Male MRN: (BIS)-002239563

Allergies: **No Known Medication Allergies**

Pharmacist please note--Allergy list may be incomplete.

Patient Address:	PO BOX 14 BOISE, ID 83707-0014	Home Phone:	(208) 000-0000
		Work Phone:	
Primary Health Plan:	CORIZON (159)	Policy/Group #:	94691/
Secondary Health Plan:		Policy/Group #:	
Third Health Plan:		Policy/Group #:	

NEW Prescription(s)

Rx: Augmentin 875 mg-125 mg oral tablet

Start Date: **12/31/2016**
Order ID# 12061952963

SIG: **1 Tab PO Q12h for 5 Day(s)**
Dispense/Supply: **<10 (Ten) Tab>**
Refill: **<No Refills>**

Rx: Motrin 600 mg oral tablet

Start Date: **12/31/2016**
Order ID# 12061953273

SIG: **1 Tab PO TID for 5 Day(s) PRN pain**
Dispense/Supply: **<15 (Fifteen) Tab>**
Refill: **<No Refills>**

VOID

DISPENSE AS WRITTEN **SUBSTITUTION PERMITTED**

Prescribed by: **Matthew Brent Campbell, MD**

Matthew Brent Campbell, MD
1055 N Curtis Rd
Boise, ID 83706
208.367.2121
Fax: 208.367.3564
Date: 12/31/2016
NPI#: 1790981025

Rx Not Valid Unless Signed By Prescriber OR Transmitted Electronically

ATTENTION: THIS RX NOT VALID FOR CONTROLLED SUBSTANCES

Saint Alphonsus Regional Medical Center
Emergency Department
1055 N. Curtis RD
Boise, ID. 83706
Phone Number 208 367-3221

EDMO, MASON D, Please provide this information to your Primary Care/Specialist

Name : EDMO, MASON D
DOB : [redacted] 12:00 PM
Unknown

Current Date : 12/31/2016 21:58:26
Primary Care Physician : Physician, PCP

Diagnosis : Scrotal laceration; Testicular injury

Follow-Up Instructions:
EDMO, MASON D has been given these follow-up instructions:

Provider:	Specialty:	Address:	Date:
PCP Unknown Physician	Family Practice; Pediatrics		Follow-up as needed

Provider:	Specialty:	Address:	Date:
Dawn K King MD	Urology	2855 East Magic View Drive Meridi ID 83642 208.639.4900 (1)	Follow-up as needed
Comment: Please contact her questions regarding wound management			

Provider:	Specialty:	Address:	Date:
Prison clinician			01/03/17
Comment: Please have medical provider remove the drain by removing the suture that is at the most distal aspect of the laceration that is sewed through the drain itself which is the last suture in the laceration all other sutures will be absorbable. This is to be removed in 2-3 days after placement. Continue by mouth anabiotic's and pain medications as needed as prescribed. If there is questions regarding wound care or other concerns regarding the procedure please contact Dr. Dawn King at the number below provided for follow-up referral.			

Laboratory Orders:

Name:	Status:
CBC with Differential	Completed
Comprehensive Metabolic Panel	Completed
Prothrombin Time	Completed
Type and Screen	Completed

Radiology Orders: None Ordered

Diagnostic Tests: None Ordered

Daniel Dellwo PA-C
JAN 01 2017
DM Does remain

Procedure(s) & Patient Education(s) : Sutured Wound Care, Easy-to-Read; Laceration Care, Adult, Easy-to-Read

Emergency Services Medication List
Lista de Medicaciones de los Servicios de Emergencia

Name EDMO, MASON D **MRN** (NG1)-001587513 **Acct#** 045365555-6366

Based on the information available during your visit we have given you the medication instructions below. Continue taking medications you took prior to your visit unless you have been told to change. Please share this information with your own doctor. Carry a list of your medications with you in case of an emergency. Update it when medications are stopped, doses are changed, or new medications (including over-the-counter products) are added. If you have any questions, check with your doctor.

Por la información disponible durante su visita, las instrucciones de medicación aparecen debajo. Favor de continuar tomando las medicaciones Ud. tomó antes de su visita por lo menos que hay cambios. Favor de compartir esta información con su médico. Lleva una lista de medicaciones consigo por caso de emergencia. Actualiza la lista cuando Ud. deja de tomar las medicaciones, si cambian las dosis, o si hay nuevas medicaciones añadidas (incluyendo medicaciones vendidas sin prescripción). Favor de preguntar a su médico por cualquier duda.

THESE ARE THE MEDICATIONS YOU SHOULD BE TAKING

Prescriptions may have been transmitted electronically to the patient's preferred pharmacy.

acetaminophen-HYDROcodone (Norco 10 mg-325 mg oral tablet) 1 Tab(s) By Mouth every 4 hours as needed for pain for 3 Days. (not to exceed 4000 mg acetaminophen