IDAHO DEPARTMENT OF CORRECTION
Medical Consideration Request Form

Offender Information

Offender's Name: ______________________________________ IDOC #: __________

Facility: ____

Consideration Information

Initiator's Name: ______________________________________

In accordance with standard operating procedure 322.02.01.003, *Holds, Cautions, Concerns, and Considerations: Offender*, I am requesting the following medical consideration on the above named offender:

- ☐ Cane
- ☐ Cotton Blanket
- ☐ Crutches
- ☐ Gym or Recreation Restriction
- ☐ Handicap Access Required
- ☐ Hearing Impaired
- ☐ Lower Bunk
- ☐ Lower Level or Tier
- ☐ Oxygen Dependant
- ☐ Vision Impaired
- ☐ Walker
- ☐ Wheelchair
- ☐ Other (written justification is required for this selection)

Consideration Start Date: ______________ Consideration End Date: _________

Comments:

When completed, email this form to the designated healthcare services staff per SOP 322.02.01.003.

Designated Healthcare Services Staff Use Only

Comments (if needed):

CIS data entry completed by: ____________________________ Date: ____________
(Print Name)

Appendix F
322.02.01.003
(Appendix last updated _______)