

Rhode Island Department of Corrections

Healthcare Services

Medication Request for Post-Release

Name: _____ Residential Program: _____
DOB: _____ ID# _____ Requestor: _____
Facility: _____ Phone No. _____ Ext: _____
Anticipated Discharge Date: _____ Date of Request: _____

Patient needs to meet one or more of the following criteria to be eligible for a thirty day supply of medication upon release. **Check all that apply:**

- _____ Releasing to residential treatment
_____ Diagnosed with chronic medical conditions that warrant medical follow-up after release.

If patient is determined ineligible, s/he will be released with a written prescription.

All requests for medications upon release will be processed through the Medical Discharge Planner. Submit completed request a minimum of **14 DAYS PRIOR TO RELEASE DATE** via an attachment to an e-mail to: Diana.Ranallo@doc.ri.gov or fax to 23222.

Medications have been received and are awaiting retrieval (fax to 23222).

Nurse Signature: _____ Date: _____

Child Waiver Section

I agree to accept my medication(s) in a non-child resistant container.

Patient Signature: _____ Date: _____

All medication(s) have been distributed to the above patient by:

Nurse Signature: _____ Date: _____

Forward the completed form to the Medical Records Unit for inclusion in patient's record.