

MEDICAL or MENTAL HEALTH ALERT

(This is not a court order)

Defendant's Name _____

Case _____

DCDC # _____ PDID# _____ DOB _____

1. **Medical Condition (including psychiatric):**

2. **Medication (dosage/frequency if known):**

3. **Special Needs:**

wheelchair _____

urinary catheter _____

other _____

4. **Primary/Treating Physician (if known)** _____

Telephone No. _____

5. **Information furnished by:** _____
please print

Defense Attorney Defendant Court Observation Other

6. **Required Signatures:**

Defendant's Signature

Attorney's Signature

Judicial Officer

Date

Received by: _____
(Deputy U.S. Marshal)

Date: _____

1 - Court 2 - USMS/DOC 3 - Defense Counsel

A copy of this form should be faxed by the Court to the DOC Medical Unit at 673-8010 ASAP