

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: _____ Date: _____

(Deputy U.S. Marshal)

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