
DATE: _____

REQUESTER: MARIA RAMIREZ
CLEMENCY DIRECTOR
CLEMENCY SECTION
(512) 406-5852

EMERGENCY MEDICAL REPRIEVE SUMMARY

NAME: _____

DATE: _____

TDCJ-CID# / SID#: _____

UNIT/LOCATION: _____

**MEDICAL HISTORY: (INCLUDING CONDITION AT TIME OF INCARCERATION;
PLEASE ADVISE IF CONDITION HAS DETERIORATED DURING THE LAST SIX
MONTHS.)**

CURRENT DIAGNOSIS:

CURRENT TREATMENT AND MEDICATION(S):

**ANTICIPATED TIME FRAMES FOR FUTURE TREATMENTS, SURGERIES,
THERAPY, ETC.:**

PROGNOSIS:

LIFE EXPECTANCY (SELECT ONE OF THE FOLLOWING OPTIONS):

- SIX MONTHS OR LESS TO LIVE**
 GREATER THAN SIX MONTHS: (PLEASE ESTIMATE THE LENGTH OF TIME)

- | | _____ MONTHS | _____ YEARS |
|-----------------------------|---|---|
| 2. PROGNOSIS: | <input type="checkbox"/> POOR | <input type="checkbox"/> FAIR |
| | <input type="checkbox"/> GOOD | <input type="checkbox"/> EXCELLENT |
| 3. CURRENT MOBILITY: | <input type="checkbox"/> COMATOSE | <input type="checkbox"/> BEDRIDDEN |
| | <input type="checkbox"/> WHEELCHAIR BOUND | <input type="checkbox"/> WALKER <input type="checkbox"/> CANE |
| | <input type="checkbox"/> AMBULATES WITH ASSISTANCE | <input type="checkbox"/> FULLY MOBILE |

(EXPECTED LENGTH OF TIME AT CURRENT MOBILITY
– YEARS/MONTHLY/WEEKS)

LEVEL OF COMPLIANCE WITH MEDICATION/TREATMENT; DESCRIBE:

RECOMMENDATION OF THE ATTENDING PHYSICIAN:

RECOMMEND CONSIDERING FOR EMERGENCY MEDICAL REPRIEVE

RECOMMEND MEDICAL CARE BE MAINTAINED AT UNIT OF ASSIGNMENT

PHYSICIAN COMPLETING SUMMARY:

UNIT/FACILITY:

DATE:

COMMENTS:

******* MEDICAL SUMMARY RESPONSE IS DUE IN FIVE (5) WORKING DAYS FROM DATE REQUEST SENT*******