

**Oregon Department of Corrections
Intake Victimization Screening Tool**

(To be completed w/in 72 hours of arrival at intake)

Institution: _____

Inmate Name: _____ SID#: _____

DOB _____ Age _____ Ht _____ Wt _____

1. Yes No Is this your first time incarcerated in a state facility (prison)?
2. Yes No Have you ever been convicted of a violent crime?
3. Yes No Do you have any disabilities?
Developmental? Yes No _____
Physical? Yes No _____
Mental? Yes No _____
4. Yes No Do you identify as any of the following? (check all that apply)
Gay ___ Bisexual ___ Transgender ___ Intersex ___
Gender non-conforming ___ Other ___
5. Yes No Have you ever been sexually abused?
If yes, did it occur in an institutional setting? _____
If yes, did it occur within the last year? _____
6. Yes No Have you ever been convicted of a sex offense against an adult or child?
7. Yes No Do you feel at risk of being sexually abused by other inmates?

Observable traits or behaviors of concern: _____

Staff Signature: _____ Date: _____

Please place completed referrals in the INTAKE box in R&D.

Immediate Notification If transgender, intersex or non-conforming:

Before 4 pm – Verbal notification to Intake Lt & email to *dl CCCF Intake Special Needs Notification*.

After 4 pm or on weekends – Verbal notification to OIC & email to *dl CCCF Intake Special Needs Notification*.

PREA considerations

If a yes to question 5 or 6, forward a copy of this form to BHS for follow up.

PCM/SART

Reviewer: _____ Date: _____ Comments: _____

This page is not part of the Health Care Record

Directions to Nursing Staff:

Verbally interview the inmate during intake screening. Intake support staff will pick up the forms in R&D daily.