The Carter House
A Family Treatment Centre

* *To be completed by a licenced physician or nurse practitioner*
* *To be completed for **all** individuals attending the treatment centre this includes children attending treatment with parents and children who have planned reunification while parents are at treatment*

MEDICAL FORM

Name (including alternate name used)	
DOB (Date/Year/Month)	
HSN	
Height (kg/lbs)	
Weight (cm/inches)	

Clinical Information				
❒ **No Known Allergies or Food intolerances**				
❒ **Allergies**	**Reaction and Side Effects**	**Severity**	**Source**	**Last Known Date of Reaction**
❒ **Medication**	❒ Difficulty Breathing ❒ Swelling ❒ Rash/Hives ❒ GI Symptoms ❒ Anaphylaxis ❒ Other	❒ Severe ❒ Intermediate ❒ Mild ❒ Unknown	❒ Client ❒ Family ❒ Other	
❒ **Non-Medication** (i.e. tape, iodine, shellfish, food - identify specific foods)	❒ Difficulty Breathing ❒ Swelling ❒ Rash/Hives ❒ GI Symptoms ❒ Anaphylaxis ❒ Other	❒ Severe ❒ Intermediate ❒ Mild ❒ Unknown	❒ Client ❒ Family ❒ Other	

Medical History	
Condition	**Details**
❒ Cancer	
❒ Depression/Mental Illness	
❒ COPD	
❒ Asthma	
❒ Epilepsy or Seizures	
❒ Heart disease or other Cardiac Condition	
❒ Hypertension	
❒ HIV/Hep C	
❒ Tuberculosis History	
❒ Pregnancy	LMP Date: Live births:
❒ Diabetes & Endocrinology	❒ Insulin Dependent ❒ Non-Insulin Dependent
❒ Skin Conditions	
❒ Other	

Specialty Care Needs	
Type	**Details:** *to include the name of the Medical Specialist(s) and Contact Number*
❒ Assistive Technology	
❒ Audiology/Hearing Health	
❒ Augmentative/Alternative Communication	
❒ Cleft Lip & Palate	
❒ Cystic Fibrosis	
❒ Developmental Delay	
❒ Ear, Nose, Throat	

❒ Gastroenterology	
❒ Genetics	
❒ Hematology	
❒ Infectious Disease	
❒ Metabolic	
❒ Nephrology	
❒ Neurology	
❒ Rheumatology	
❒ Autism	
❒ Specialized Feeding	
❒ Orthopedics	
❒ Other	
Note: Please attach relevant documents and/or referrals	

Rehabilitative Program in Progress	
Type	**Details:** *to include the name of the Medical Specialist(s) and Contact Number*
❒ Nutrition	
❒ Occupational Therapy	
❒ Physical Therapy	
❒ Speech Language Pathology	
❒ Psychology	
❒ Other	
Note: Please attach relevant documents and/or referrals	

Medications				
	Name	**Dosage**	**Frequency**	**Route**

Prescribed Medication				
Over The Counter Medication				
Controlled Substances				

Is this client able to attend an intensive in-patient addiction treatment program involving individual counselling, group session? Note: this would include them not having a communicable illness such as TB, Covid etc.

❒ Yes

❒ No

If no, please explain:

Is this client able to perform group recreation sessions including yoga, walking (up to 1 kilometer)?

❒ Yes

❒ No

If no, please explain:

Are there any current concerns medical or psychiatric that would preclude this client from attending an in-patient addiction treatment program?

❒ Yes

❒ No

If yes, please explain:

If this is a child – the above questions must be answered in addition to the list outlined below:
Are their immunizations up to date including chicken pox?

❒ Yes

❒ No

If no, please explain:

****NOTE: THE APPLICATION WILL BE REJECTED IF ALL QUESTIONS ARE NOT ANSWERED AND IF NOT ACCOMPANIED BY A CURRENT MEDICAL PROFILE AND CURRENT LIST OF MEDICATIONS**

Signature: _____

Printed Name/Title: _____