

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

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

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

<input type="checkbox"/> Gastroenterology	
<input type="checkbox"/> Genetics	
<input type="checkbox"/> Hematology	
<input type="checkbox"/> Infectious Disease	
<input type="checkbox"/> Metabolic	
<input type="checkbox"/> Nephrology	
<input type="checkbox"/> Neurology	
<input type="checkbox"/> Rheumatology	
<input type="checkbox"/> Autism	
<input type="checkbox"/> Specialized Feeding	
<input type="checkbox"/> Orthopedics	
<input type="checkbox"/> 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
<input type="checkbox"/> Nutrition	
<input type="checkbox"/> Occupational Therapy	
<input type="checkbox"/> Physical Therapy	
<input type="checkbox"/> Speech Language Pathology	
<input type="checkbox"/> Psychology	
<input type="checkbox"/> 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: _____