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 (MM/DD/YYYY)	
HSN	
Height (cm/inches)	
Weight (kg/lbs.)	
Gender (Male/Female/Other)	
Band	
Status (Treaty)	

Clinical Information				
☐ **Food Intolerances**				
☐ **Allergies**	**Reaction and Side Effects**	**Severity**	**Source**	**Last Known Date of Reaction**
☐ **Vital Signs**	**B/P**	**Pulse**	**Temp**	
☐ **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 Health	
❒ COPD	
❒ Asthma	
❒ Epilepsy or Seizures	
❒ Heart disease or other Cardiac Condition	
❒ Hypertension	
❒ HIV/Hep C	
❒ Tuberculosis History	
❒ Skin Conditions	
❒ Pregnancy	LMP Date: Live births:
❒ Diabetes & Endocrinology	❒ Insulin Dependent ❒ Non-Insulin Dependent
❒ 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:** *including 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:

***Important:** Applications will be rejected if all questions are not fully answered and if they are not accompanied by a **current medical profile** and an **up-to-date list of medications**.
Please ensure that all sections are completed and that your medical information and medication list are current before submitting your application.

COMPLETED FORM TO BE FAXED TO 1-306-206-0577 OR EMAILED TO INFO@THECARTERHOUSE.NET

Signature:

Printed Name/Title: