



Mental Health and Addictions
Youth Treatment Centre

Medical Assessment For Referral

Name: _____

HCN #: _____

Date of Birth: _____ (DD/MONTH/YYYY)

Date: _____ DD/MONTH/YYYY

CRMS #: _____

This youth is referred to the Youth Treatment Center for Youth with Complex Mental Health Needs (Paradise), where he/she will participate in an inpatient treatment program.

1. PERSONAL INFORMATION	
Phone #: _____	Address: _____
Primary Physician/NP: _____	Phone #: _____
Allergies: _____	

2. CURRENT MEDICATIONS (please include OTC and Supplements)		
Medication	Dosage	Reason for Prescription

If applicable, is Nicotine Replacement Therapy safe for this youth? Yes No N/A

3. BRIEF MEDICAL / SOCIAL HISTORY	
Past Medical History/Mental Health Concerns/Substance Use:	
Past Social History:	
Past Family History/Mental Health Concerns/Substance Use:	

SIGNATURE: _____ PRINT: _____ DATE: _____ dd/mm/year

Eastern Health acknowledges and respects the privacy of individuals. This personal information is being collected under the authority of Sections 32 and 33 of the Access to Information and Protection of Privacy Act. And will be used for processing your request for Mental Health and Addictions Services. Please direct any questions about this collection to: Privacy Officer, Eastern Health, Quality and Risk Management, 12th Floor Southcott Hall, 777-8025.



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4. PHYSICAL EXAM					
Height: _____	Weight: _____	Blood Pressure: _____	Pulse: _____		
Gravida: _____	Term: _____	Premature: _____	Abortuses: _____	Living: _____	N/A: <input type="checkbox"/>
	N	ABN		N	ABN
General Appearance:	<input type="checkbox"/>	<input type="checkbox"/>	Lungs	<input type="checkbox"/>	<input type="checkbox"/>
Head	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen	<input type="checkbox"/>	<input type="checkbox"/>
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	GI/GU	<input type="checkbox"/>	<input type="checkbox"/>
Ears	<input type="checkbox"/>	<input type="checkbox"/>	MSK	<input type="checkbox"/>	<input type="checkbox"/>
Nose	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>
Throat	<input type="checkbox"/>	<input type="checkbox"/>	Neurological	<input type="checkbox"/>	<input type="checkbox"/>
Neck	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac	<input type="checkbox"/>	<input type="checkbox"/>			
Comments regarding physical exam:					

5. COMMUNICABLE DISEASE:					
Are immunizations up to date: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
To your knowledge, does the youth have any of the following:					
	Yes	No		Yes	No
HIV	<input type="checkbox"/>	<input type="checkbox"/>	Strep Throat	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Turberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Mononeucleosis	<input type="checkbox"/>	<input type="checkbox"/>
Diphtheria	<input type="checkbox"/>	<input type="checkbox"/>	Influenza	<input type="checkbox"/>	<input type="checkbox"/>
Pertussis	<input type="checkbox"/>	<input type="checkbox"/>	Impetigo	<input type="checkbox"/>	<input type="checkbox"/>
Varicella	<input type="checkbox"/>	<input type="checkbox"/>	Infestations	<input type="checkbox"/>	<input type="checkbox"/>
Menengitis	<input type="checkbox"/>	<input type="checkbox"/>	STIs	<input type="checkbox"/>	<input type="checkbox"/>
Measles	<input type="checkbox"/>	<input type="checkbox"/>	Conjunctivitis	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Enteric Illness	<input type="checkbox"/>	<input type="checkbox"/>
Rubella	<input type="checkbox"/>	<input type="checkbox"/>	Tinea Coporsis/Pedis	<input type="checkbox"/>	<input type="checkbox"/>
Plantar Warts	<input type="checkbox"/>	<input type="checkbox"/>	Other:		

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Comments regarding communicable diseases:

6. MEDICAL FOLLOW-UP	
Do you suggest any medical follow-up while the youth is at the Youth Treatment Centre?	
Illness / Issue / Concern:	Suggested Follow-up:

Signature of Physician / Nurse Practitioner Print (DD/MONTH/YYYY)
Date

Signature of Youth Print (DD/MONTH/YYYY)
Date

SIGNATURE: _____ PRINT: _____ DATE: _____ DD/MONTH/YYYY