Eastern Health

Adult Addictions Inpatient Treatment
MEDICAL ASSESSMENT FORM
(Part I)

CL1980 1391 09 2015

Western Health

Name

HCN

Date of Birth

Address: _____ Telephone: _____

Physician's Name: _____

Address: _____

Telephone: _____ Fax: _____

This client is to be referred to the treatment centre, where he/she will participate in an inpatient treatment program designed to explore alcohol/drug dependency issues and/or problem gambling behavior.

Allergies: ❑ ***No Known***

Physical Examination: Height: _____ Weight: _____ Blood Pressure: _____

Brief Medical History (including psychiatric problems): _____

_____

_____

_____

_____

Stomach Issues: ❑ Yes ❑ No _____
Gout: ❑ Yes ❑ No _____
Liver Issues: ❑ Yes ❑ No _____
Hepatitis: ❑ Yes ❑ No _____
Seizures ❑ Yes ❑ No _____
Mental Health Issues: ❑ Yes ❑ No (i.e. Depression, Anxiety) _____

Is the client currently in a healthcare facility? ❑ Yes ❑ No If Yes:
Where: _____
Admission date: _____ Projected discharge date: _____
Reason for admission: _____

**** It is vital to forward discharge notes or consults.***

Examination (degree of abdominal hepatomegaly, spider nevi, tremors):
(Please include a copy of most recent blood work completed)

_____

_____

_____

_____

_____

_____

Could the client be pregnant? ❑ Yes ❑ No
Any physical limitations or special needs? ❑ Yes ❑ No If yes, please explain: _____

_____

_____

Physician/Nurse Practitioner's Name: _____ Date: DD/MONTH/YYYY

Physician/Nurse Practitioner's Signature: _____

Eastern Health

Adult Addictions Inpatient Treatment MEDICAL ASSESSMENT FORM (Part II)

CL1980 1391 09 2015

Western Health

Name

HCN

Date of Birth

Please identify any of the following that may apply to this client:

☐ limited vision ☐ limited hearing ☐ learning disability ☐ language barrier
☐ intellectual disability ☐ developmental disability ☐ cognitive problems ☐ language impairment
☐ memory problems ☐ speech impairment ☐ other:_____

Is the client able to walk, feed, dress, bathe and care for self? ❑ Yes ❑ No
If No, please explain: _____

_____

Is physical nursing care required? ❑ Yes ❑ No
If yes, please explain: _____

_____

Are you aware of any communicable conditions the client has which could affect the health of other residents or staff in a group setting? ❑ Yes ❑ No
If yes, please explain:_____

_____

Has this client had the flu vaccine? ❑ Yes ❑ No

Do you suggest any medical follow-up while the client is at the treatment centre?

Problem: Follow-Up:

_____ _____
_____ _____
_____ _____

In your opinion, is the client able to participate in the treatment program (i.e., able to concentrate, take part in physical activity)? ❑ Yes ❑ No

In your opinion, is Nicotine Replacement Therapy safe for this client (i.e. gum, patch)? ❑ Yes ❑ No

Has the client began a smoking cessation or NRT program? ❑ Yes ❑ No

If yes, please explain:_____

_____

CURRENT MEDICATIONS

Name	Dosage	Frequency	Reason for Use

Physician/Nurse Practitioner's Name:_____ Date:DD/MONTH/YYYY

Physician/Nurse Practitioner's Signature:_____

Eastern Health

Adult Addictions Inpatient Treatment
MEDICAL ASSESSMENT FORM
(Part III)

Western Health

Name

HCN

Date of Birth

Comments:_____
_____
_____
_____
_____
_____
_____
_____

Is the client currently being prescribed Methadone as a treatment for addiction or pain? ❑ Yes ❑ No

If Yes, Dosage: _____ Length of time on that dose: _____

Prescribing Physician:

Name: _____ **Telephone:** _____

Fax Number: _____

Is the client willing to taper off Methadone, if necessary? ❑ Yes ❑ No

Signature of Client:_____ Date:DD/MONTH/YYYY

Physician/Nurse Practitioner's Name:_____ Date:DD/MONTH/YYYY

Physician/Nurse Practitioner's Signature:_____

Eastern and Western Health acknowledges and respects the privacy of individuals. The personal information is being collected under the author of sections 29, 30 and 31 of the Personal Health Information Act and will be used for processing your referral application. If you have any questions about the collection of this information, please contact Eastern Health, Regional Access & Privacy office (709) 777-8025. Western Health Regional Access & Privacy Office (709) 637-5000 ext. 5248