Central Health

MEDICAL ASSESSMENT FORM
YOUTH TREATMENT CENTRE

Mental Health and Addictions Medical Assessment Form

First Name:	
Last Name:	
Date of Birth:	
CRMS #:	
MCP/HCN #:	

Physician/NP Name: _____

Physician/NP Address: _____

Physician/NP Telephone #: _____

Physician/NP Facsimile #: _____

Allergies: _____

Diagnosis	Diagnosed by	Diagnosis Date

CURRENT MEDICATIONS (include OTC and Supplements)

Current Drug	Prescribed Dosage	Prescribed for

Brief Medical History (including mental health issues):

Past Medical History: _____

_____

Past Social History: _____

_____

OB/GYN: _____

_____

Mental Health: _____

_____

Vital Signs: Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

Physical Examination:

_____

_____

_____

Are immunizations up to date?	☐ Yes	☐ No
Could the youth be pregnant?	☐ Yes	☐ No
Does the youth have diabetes?	☐ Yes	☐ No
Does the youth epileptic?	☐ Yes	☐ No
Does the youth engage in self-harm behavior?	☐ Yes	☐ No
Is the youth currently suicidal?	☐ Yes	☐ No
Has youth had past suicidal ideation?	☐ Yes	☐ No
Has youth had past suicide attempts?	☐ Yes	☐ No

To your knowledge, does the youth have any of the following conditions?

Skin rash	☐ Yes	☐ No
Scabies	☐ Yes	☐ No
Plantar Warts	☐ Yes	☐ No
Athlete's foot	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No

Are you aware of any other communicable conditions the youth has which could affect the health of other residents or staff in a group setting? ☐ Yes ☐ No

Explain: _____

_____

Do you suggest any medical follow-up while the youth is at the Youth Treatment Centre?

Problem:	Suggested Follow-Up:
_____	_____
_____	_____
_____	_____

In your opinion, is the youth able to participate in the treatment program (i.e., able to concentrate, take part in therapeutic activities)? Yes ☐ No ☐

Comments: _____

_____

_____

Does the youth have any physical restrictions? Yes ☐ No ☐

Explain: _____

_____

_____

Does the youth use tobacco products? Yes ☐ No ☐

If yes, is Nicotine Replacement Therapy safe for this youth (i.e. gum, patch)?
Yes ☐ No ☐

Comments: _____

_____

_____

Are there any medical concerns not mentioned on this form in which Youth Treatment Centre staff should be aware? Yes ☐ No ☐

Comments: _____

_____

_____

Date: _____

_____ _____

Signature of Physician/Nurse Practitioner Signature of Youth and Parent/Guardian