Newfoundland Labrador

Name: _____

HCN: _____

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

Adult Addictions Medical Assessment

Name: _____

Mailing Address: _____ Telephone: _____

City: _____ Province/Territory: _____ Postal Code: _____

Physician/Nurse Practitioner: _____

Mailing Address: _____

City: _____ Province/Territory: _____ Postal Code: _____

Telephone: _____ Fax: _____

This client is being referred to a treatment center, where they will participate in an inpatient treatment program designed to explore substance use and/or gambling behavior.

○ No known Allergies

Allergies: (Please specify allergy and reaction)

Height:		Temp:	
Weight:		Pulse:	
BMI:		Respiration Rate:	
Pulse Ox:		Blood Pressure:	
Heart:			
Abdominal:			
Neurological:			

Other pertinent assessment findings: (Please include a copy of most recent labs and other relevant diagnostic tests).

Physician/Nurse Practitioner's Name: _____ Date (YYYY/MON/DD): _____

Physician/Nurse Practitioner's Signature: _____

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List prescribed drugs and over-the-counter drugs (such as vitamins and inhalers)

(If more space required please attach list)

Name the Drug	Strength/Dosage	Frequency Taken

Is the client currently being prescribed benzodiazepine? ◯ Yes ◯ No

If yes, is there a plan to taper the medication prior to treatment? ◯ Yes ◯ No

Please specify:

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

Is the client currently being prescribed Suboxone as a treatment for addiction? ◯ Yes ◯ No

If yes to Methadone/Suboxone - Dosage:

Length of time on that dose:

Prescribing Physician/ Nurse Practitioner:

Telephone: Fax:

Physician/Nurse Practitioner's Name: Date (YYYY/MON/DD):

Physician/Nurse Practitioner's Signature:

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Adult Addictions Medical Assessment

Dispensing Pharmacy:

Telephone: Fax:

Does the client use nicotine? ○ Yes ○ No

Is nicotine replacement therapy (NRT) safe for this client (i.e. gum, patch) ○ Yes ○ No

Has the client started a smoking cessation or NRT program? ○ Yes ○ No

Will the client require withdrawal management prior to commencing treatment? ○ Yes ○ No

Is there a history of withdrawal seizures or DT's? ○ Yes ○ No

Comments:

Are there any chronic medical conditions that need to be monitored during the person's stay? If yes, please provide details of condition and monitoring that is required:

Are there any mental health issues that have a bearing on the person's ability to participate in groups/ structured activities? Please specify:

Could this client be pregnant? ○ Yes ○ No

Is the client currently in a healthcare facility? ○ Yes ○ No

If yes, where:

Physician/Nurse Practitioner's Name: _____ Date (YYYY/MON/DD): _____

Physician/Nurse Practitioner's Signature: _____

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

Adult Addictions Medical Assessment

Admission date (YYYY/MON/DD): _____

Projected discharge date (YYYY/MON/DD): _____

Reason for admission:

It is vital to forward discharge notes and/or consults

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:

Physician/Nurse Practitioner's Name: _____ Date (YYYY/MON/DD): _____

Physician/Nurse Practitioner's Signature: _____

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