Adult Addictions Inpatient Treatment
MEDICAL ASSESSMENT FORM
(Part I)

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: ______________________________

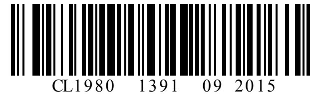
____

____

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

Physician/Nurse Practitioner's Signature: ______________________________

Adult Addictions Inpatient Treatment MEDICAL ASSESSMENT FORM (Part II)



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:____

____

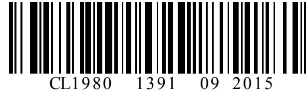
CURRENT MEDICATIONS

Name	Dosage	Frequency	Reason for Use

Physician/Nurse Practitioner's Name:______________________________ Date:___DD/MONTH/YYYY___

Physician/Nurse Practitioner's Signature:______________________________

Adult Addictions Inpatient Treatment MEDICAL ASSESSMENT FORM (Part III)



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