Medical Clearance

PRESCRIPTION DRUG MISUSE (PDM) REFERRAL PACKAGE

(Please Print)

VITALS AT TIME OF VISIT:			
BP:	Pulse:	Blood Glucose Level (if applicable):	Weight:

CLIENT INFORMATION

TO BE COMPLETED BY DOCTOR/NURSE PRACTIONER/NURSE

Last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status:	
Home Community (Band)	Ban ber (its)	(Former/Maiden name):	Birth ate: MM/YY d	Age:	Sex: ❑ M	❑ F
Community Currently Residing in:		Health Card #:		Home phone #: ( )		
Current Address		Province:		Postal Code:		
Are you this client's family doctor?	❑ Yes	❑No	If NO, provide Name of Family Doctor:			

MEDICATION *IF MORE SPACE IS REQUIRED ATTACH SEPARATE SHEET!!*

Please Indicate all if any medications (methadone included) that this client is currently taking, please included over the counter.

Type of Medication	Dose	Times/day	Purpose of this medication	How long has this client been on this?

Does this client have any limitations that would prevent him/her from participating in the PDM - Day Program?	❑ Yes	❑ No
Explain:		

Medical Conditions:	❑ Diabetes Type ❑ 1 ❑ 2	❑ Hypertension	❑ Migraines	❑ Heart Condition	❑ Epilepsy Last episode:	❑ Other

Conditions Stabilized?	❑ Yes	❑ No	Explain:		
Allergies:	❑ Yes	❑ No	Allergic to:		
TB TEST <u>MANDATORY Prior to Admission</u> Memo from Health Canada August 2011	**❑ Yes**	**❑ No**	**Test results:**	**Doctor:**	
			Did this Client Receive Treatment: ❑ **Yes** ❑ **No**	**Phone #:**	
			If Yes with what medication?	**When:**	
Has this Medical Changed in the Past year?	❑ Yes	❑ No	Date of last Physical?		

Client agrees to Provide a copy of Medication list from a recognized pharmacy	❑ Yes	❑ No	*Client Signature:*
Client's drug of Choice?			Date of Last use: DD/MM/YY

SIGNATURE REQUIRED

Name Of Health Professional/Doctor/NP /Nurse (Please Print)	Involved with Client # of Days/Months/Yrs.	Office phone no.: ( )	Office fax no.: ( )

The above information has been completed by me (the health professional) and I verify all to be true. *Completed at this office.*

Doctor/NP /Nurse signature	***Office Stamp***	Date of Physical: DD/MM/YY