ORT
Medical Clearance Form

(PLEASE PRINT)

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

CLIENT INFORMATION

TO BE COMPLETED BY CURRENT METHADONE/SUBOXONE DOCTOR

Last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status:	
Home Community (Band)	Band Number (10 Digits)	(Former/Maiden name):	Birth date: DD/MM/YY	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?

Please Confirm - this client is NOT on medicinal Marijuana (THC)	**❑ YES**	**❑ NO**
Has this client been involved with IV drug use?	❑ Yes	❑ No

Has this client been tested for	HIV	RESULT	Hepatitis A B C	Result

Medical Conditions:	❑ Diabetes Type ❑ 1 ❑ 2	❑ Hypertension	❑ Migraines	❑ Heart Condition	❑ Epilepsy Last episode:	❑ Other
Conditions Stabilized?	❑ Yes	❑ No	Explain:			
Allergies:	❑ Yes	❑ No	Allergic to:			
Shows signs Of TB Prior to Admission	**❑ 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?			

_____ I have completed the Doctor Verification Form and have attached it to this medical Form

_____ I will agree to contact the Medicine Shoppe pharmacy as directed on the Doctor Verification form. Once the client is accepted. In a timely fashion the required transfer will take place.

SIGNATURE REQUIRED

Name Of Doctor (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 signature	***Office Stamp***	Date of Physical: DD/MM/YY