ORT

Medical Clearance Form

CLIENT INFORMATION (PLEASE PRINT)					
TO BE COMPLETED BY CURRENT METHADONE/SUBOXONE DOCTOR					
Last name:	First:	Middle:			
Home Community (Band)	Band Number (10 Digits)	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	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 <u>Prior to Admission</u>	❑ **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?			

SIGNATURE REQUIRED			
Name Of Doctor (Please Print)	Involved with Client # of Days/Months/Yrs.	Office phone no.: ( )	Office fax no.: ( )
<u>The above information has been completed by me (the health professional) and i verify all to be true. Completed at your office.</u>			
Doctor signature	***Office Stamp***	Date of Physical: DD/MM/YY	

The Rising Sun has an inferred sauna, does this client have any limitations that would prevent this client from using the sauna equipment?	❑ Yes ❑ No	Please explain: