



APPLICANT'S NAME (PLEASE PRINT) \_\_\_\_\_

**CONFIDENTIAL**

**Client Health Information**

**APPLICANTS MUST HAVE THIS FORM COMPLETED BY A PHYSICIAN.**

HISTORY OF:		CHECK ONE		PLEASE EXPLAIN "YES" RESPONSES
		YES	NO	
1	Allergies			
2	Central Nervous System			
3	Epilepsy, Withdrawal Seizures			
4	Pain: Acute, Chronic			
5	Mental Health Disorders			
6	Suicidal Thoughts			
7	Attempted Suicides			
8	Drug or Alcohol Abuse or Addiction			
9	Eating disorder			
10	Sleeping disorders			
11	Respiratory System Disorders			
12	Circulatory System Disorder B/P ____/____			
13	Gastrointestinal Disorder			
14	Hepatic Disorder (i.e. HCV +, HBV, Hepatitis)			
15	Pancreatic Disorder (i.e. Diabetes, Pancreatitis)			
16	Urinary System Disorder			
17	Reproductive System Disorder			
18	Are you, or could you be pregnant? If yes, what is your due date? _____			
19	STDs, HIV +, AIDS			
20	Other health problems or recent hospitalization			
<b>TB SCREENING: SYMPTOMS AND HISTORY</b>				
21	Presence of cough lasting more than 2 weeks			
22	Weight Loss ____#lbs ____ length of time			
23	Night Sweats			
24	Fever			
25	Fatigue			
26	Haemoptysis (blood in Sputum)			
27	Recent or past exposure to TB			
28	Previous active TB and treatment			
29	Previous significant Manyox results or Chest X-ray results			
30	Extensive Travel (or birth) in a country with a high incidence of TB			
31	Other risk factors for infection (aboriginal, elderly, homeless, health care worker)			
32	Poor general health status and risks factors for progression of disease			
<b>ACTIONS</b>				
33	Further TB screening or assessment required (if "yes" please fax results to Centre)			



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**Client Health Information (continued)**

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CURRENT MEDICATIONS (including prn meds and OTC)		
MEDICATION	PRESCRIBED BY	LENGTH OF TIME USED

Are there any special problems (physical or psychological) that should be considered in the treatment of this applicant (for example, Difficulty with stairs or long corridors, anxiety attacks, etc.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**\*Please attach:**

- Relevant medical, laboratory or radiological reports
- Recent Psychological assessment or evaluations

**Please remind the applicant:** In order to be admitted to residential treatment, the applicant must be well enough to participate in the program. Typically, this required at least five days of abstinence from alcohol and other drugs.

**Are you the applicant's Physician?**       Yes     No

**Do you require a copy of the applicant's treatment discharge summary?**       Yes     No

Physician (Print) \_\_\_\_\_ Signature \_\_\_\_\_

Mailing Address \_\_\_\_\_ Postal Code \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

**Are you affiliated with a Primary Care Network? If so please provide it'd name and address.**

Name: \_\_\_\_\_

Mailing Address \_\_\_\_\_ Postal Code \_\_\_\_\_

*I hereby authorize the above named physician to release to the nursing staff at the Thorpe Recovery Centre, medical information which is required to assess my suitability for acceptance and admittance to the residential treatment program.*

**Applicant Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Date Health Assessment Completed:** \_\_\_\_\_