

## MEDICAL CLEARANCE FOR TREATMENT

The individual noted below has requested entry to residential addiction treatment services at the Behavioural Health Foundation. Please assess, and provide all of the information requested. BHF is a trustee under the Personal Health Information Act.

(Please Print Clearly)

Patient's name:		Date:
PHIN #:	MHSC#:	Date of Birth:
Doctor's name:	Hospital/Medical Clinic:	
Blood Pressure:	Pulse:	Respirations:
Has client been checked for lice and scabies? Yes No      Is treatment required? Yes No		

Client's active medical concerns:	Client's inactive medical concerns:

### Client medication information

All client medications must be documented below. All medications need to be properly packaged, including client name, physician name, pharmacy, dosage amounts and time(s) of administration, and the date of prescription issue.
How effective have these medications been?

Was client provided with a prescription today? Yes No
Name of medication? <span style="float: right;">Dosage:</span>
Medical clearance: _____ cleared to participate in BHF programming _____ not cleared to participate in BHF programming Reason: _____
<input type="checkbox"/> I understand if referral fails to bring either a current prescription and a method of payment, or a minimum 2 week supply of all medications, s/he will be without medication during her/his initial stay.
Physician Comments:

Physician Signature: \_\_\_\_\_ Date Issued: \_\_\_\_\_