MEDICAL CLEARANCE FOR TREATMENT

The individual noted below has requested entry to residential addiction and co-occurring mental health 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.

MUST BE COMPLETED BY A PHYSICIAN OR NURSE PRACTITIONER

(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 ☐		
Checked for other communicable infections: Yes ☐ No ☐		
Is client currently pregnant? 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? Dosage:
Medical clearance: _____ cleared to participate in BHF programming _____ not cleared to participate in BHF programming Reason: _____ ❑ I understand if referral fails to bring either a current prescription and a method of payment, or a minimum 2-4 week supply of all medications, he/she will be without medication during her/his initial stay. ❑ I will be providing primary medical/mental health care for this client as needed during his/her treatment at BHF (name, address and phone number) _____ or ❑ The following Physician or Nurse Practitioner will be providing primary medical/mental health care for this client during treatment at BHF (name, address and phone number) _____
Physician Comments:

Physician Signature: _____ Date Issued: _____