

Medical Form

To be completed by a licensed physician or primary health care nurse:

Patient Date of Birth: Patient Hospitalization Number: Physician Name: Physician Signature: Physician Signature: Phone Number: Fax Number: Fax Number: Phone Number: Fax Number: Fax Number: Phone Number: Fax Number: Phone Number: Fax Number: Fax Number: Phone Number: Fax Number:	Patient Name:						
Physician Name: Physician Signature:	Last N	ame		First Nam	e	Initial	
Physician Name: Physician Signature:	Patient Nate of Rirth				Patient Hospitalization Number		
Phone Number:	Day /	Month / Year			r attent riospitanz	action Number.	
Phone Number:	Physician Namo:				Dhysician Signatu	ro.	
Please check yes or no to indicate if client is being treated for or if they have a history of any of the following: Yes No When and give details if applicable	riiysiciaii Ndiile:				rifysician signature		
Please check yes or no to indicate if client is being treated for or if they have a history of any of the following: Yes No When and give details if applicable	Phone Number:				Fax Number:		
Tuberculosis Heart Disease Mental Illness Epilepsy Seizure's – other than epilepsy High Blood Pressure Allergy Stroke Diabetes Back Pain Venereal Disease Emphysema or other lung disease HIV / AIDS Hepatitis A B C Empression Lice Pregnancy LM.P. DATE: Day / Mooth / Year Current Medications Dosage Reason / Comments Please list any further information that you feel may be of benefit to this Centre – use back if needed.							
Tuberculosis Heart Disease Mental Illness Epilepsy Seizure's – other than epilepsy High Blood Pressure Cancer Allergy British Back Pain Venereal Disease Emphysema or other lung disease HIM / AIDS Hepatitis A B C Scabies Lice Pregnancy L.M.P. DATE: Day/Month/Year Live Births: Current Medications Dosage Reason / Comments Please list any further information that you feel may be of benefit to this Centre – use back if needed.	Please check yes or no to indica	ate if client is	s bein	g treated fo	r or if they have a	history of any of the following:	
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Heart Disease Mental Illness Epilepsy Seizure's – other than epilepsy High Blood Pressure Cancer Allergy Stroke Diabetes Back Pain Venereal Disease Emphysema or other lung disease HIV / AIDS Hepatitis A B C Scabies Lice Tregnancy L.M.P. DATE: Day/Month/Year Eurrent Medications Dosage Reason / Comments Please list any further information that you feel may be of benefit to this Centre – use back if needed.		Y	es	NO	When	and give details if applicable	
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Cancer Allergy Stroke Diabetes Back Pain Venereal Disease Emphysema or other lung disease HIV / AIDS Hepatitis A B C Scabies Lice Pregnancy L.M.P. DATE: Day/Month/Year Live Births: Current Medications Dosage Reason / Comments Please list any further information that you feel may be of benefit to this Centre – use back if needed.							
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Diabetes Back Pain Venereal Disease Emphysema or other lung disease HIV / AIDS Hepatitis A B C Scabies Lice Pregnancy L.M.P. DATE: Day / Month / Year Live Births: Special Diet: Current Medications Dosage Reason / Comments Please list any further information that you feel may be of benefit to this Centre – use back if needed.	Allergy						
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Venereal Disease Emphysema or other lung disease HIV / AIDS Hepatitis A B C Scabies Lice Pregnancy L.M.P. DATE: Live Births: Special Diet: Current Medications Dosage Reason / Comments Please list any further information that you feel may be of benefit to this Centre – use back if needed.	Diabetes						
Emphysema or other lung disease HIV / AIDS Hepatitis A B C Scabies Lice Pregnancy L.M.P. DATE: Day / Month / Year Live Births: Special Diet: Current Medications Dosage Reason / Comments Please list any further information that you feel may be of benefit to this Centre – use back if needed.	Back Pain						
HIV / AIDS Hepatitis A B C Scabies Lice Pregnancy L.M.P. DATE: Day / Month / Year Live Births: Current Medications Dosage Reason / Comments Please list any further information that you feel may be of benefit to this Centre — use back if needed.	Venereal Disease						
Repatitis A B C	Emphysema or other lung disease						
Scabies Lice Pregnancy L.M.P. DATE: Day/Month/Year Live Births: Special Diet: Current Medications Dosage Reason / Comments Please list any further information that you feel may be of benefit to this Centre – use back if needed.	HIV / AIDS						
Pregnancy L.M.P. DATE: Day/Month/Year Live Births: Current Medications Dosage Reason / Comments Please list any further information that you feel may be of benefit to this Centre – use back if needed.	Hepatitis A B C						
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Special Diet: Current Medications Dosage Reason / Comments Please list any further information that you feel may be of benefit to this Centre – use back if needed.	Lice						
Current Medications Dosage Reason / Comments Please list any further information that you feel may be of benefit to this Centre – use back if needed.	Pregnancy	L.N	И.Р. [DATE:		Live Births:	
Current Medications Dosage Reason / Comments Please list any further information that you feel may be of benefit to this Centre – use back if needed.	Special Diet:			Day / Mo	onth / Year		
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	Current Medications		Dosage		Reason / Com	ments	
	Please list any further inform	nation that v	you f	eel may be	of benefit to this	s Centre – use back if needed.	
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Current Medications	Dosage	Reason/Comments					
** All medications prescribed or non-prescribed (including any vitamins) must be bubble packed with a twenty eight (28) day supply. All medications are to be given to staff upon arrival for safe storage and will be dispensed by staff at designated times.							
** Methadone Carries must be transferred to specific pharmacy prior to Intake.							
Saskatoon: Rexall Drug Store – 1530 20 th Street West Saskatoon – 306-652-6822							
Prince Albert: Medi-Centre Pharmacy – 2685 2 nd Avenue West – 306-763-2022							
Regina: College Ave Drugs – 636 College Avenue – 306-525-2513							
** Any suicide attempts within six (6) months of treatment date must be accompanied by a mental health assessment stating client is stabilized to attend the 28-day Inpatient Treatment Program.							
If client has been under the care of a psychiatrist in the last 3 - 6 months please provide a psychiatric evaluation.							
Please list any further information that you feel may be of benefit to this centre:							
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Signature:		Date:					
By signing this form I give authorization for any medical information that the above physician may possess to be released.							
Patient Signature		Date					