MEDICAL FORM

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

Patient Name:_____
Last Name First Name Initial

Patient Date of Birth:_____ Patient Hospitalization Number:_____

*** Please check yes or no to indicate if client is being treated for or if they have a history of the following:**

	Yes	No	When and include treatment details if applicable
Allergy			
Back Pain			
Cancer			
COVID 19			**Test Date:** **Quarantined: YES or NO**
Diabetes			**Type:**
Depression			
Emphysema - or other lung disease			
Epilepsy			
Fever			**Temp:**
Heart Disease			
Hepatitis A B C			
High Blood Pressure			
HIV / AIDS			
Lice			
Mental Illness			**Diagnoses:**
Scabies			
Seizures – other than Epilepsy			
Stroke			
Suicide Attempts			**Last attempt:**
Tuberculosis			
Vaccination Type i.e. Influenza			
Pregnancy	**L.M.P. DATE:** **Day / Month / Year**		**Live Births:**
Special Diet:			

Non-Prescribed Meds/Vitamins	Dosage	Reason/Comments

Prescribed Medications	Dosage	Reason / Comments

**All medications prescribed or non-prescribed (including vitamins) must be bubble-packed with a 28-day supply.

**All medications are to be given to staff upon arrival for safe storage and will be overseen by staff at designated times.

**ALL MEDICATION AND VITAMINS IN *BOTTLES WILL NOT* BE ACCEPTED AT ANY TIME INCLUDING ANY PAIN RELIEF MEDICATION.

**Methadone carries must be transferred to specific pharmacy prior to intake:

Prince Albert: Medi-Centre Pharmacy – 2685 2nd Avenue West – 306-763-2022

Saskatoon: Rexall Drug Store – 1530 20th Street West – 306-652-6822

Regina: College Avenue Drugs – 636 College Avenue – 306-525-2513

** Any suicide attempts within 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.

THE MACSI EXECUTIVE DIRECTOR MUST PRE-APPROVE THE CLIENT FOR TREATMENT IF THEIR HAS BEEN AN ATTEMPT WITHIN 6 MONTHS. A Suicide risk assessment will be completed and a safety plan determined.

** If client has been under the care of a psychiatrist in the last 3 – 6 months please provide a psychiatric Evaluation and contact information.

** If a full physical examination was done, please provide copy. Thank you.
Please list any further information that you feel may be of benefit to this Centre:

_____

_____

_____

*ALL INFORMATION AND SIGNATURES MUST BE INCLUDED AT THE TIME OF COMPLETING THIS FORM.

Physician Name:_____ Physician Signature:_____

Phone Number:_____ Fax Number:_____

***By signing this form, I give authorization for any medical information that the above physician may possess to be released.*

Patient Signature:_____ Date:_____

COMPLETED MEDICAL FORMS WILL EXPIRE AFTER 90 DAYS