Native Addictions Council of Manitoba

NACM Outreach / Pritchard House

Phone: 204.586.8395 / Fax: 204.589.3921

MEDICAL ASSESSMENT

(To be completed by MD, NP or RN)

Client Personal Identification:

First Name: _____ Last Name: _____

Birthday: Year _____ Month _____ Day _____ Age _____

Gender: Male _____ Female _____ Transgender _____

Provincial Health Number: _____ PHIN: _____

Treaty Number: _____

Informed Consent Must Be Completed With Client:

I, (client's name) _____ do hereby request and give permission to _____to release medical facts and assessment about myself to Native Addictions Council of Manitoba/Pritchard House. The photocopy of my signature on this form is as valid as the original.

Client's Signature: _____ Date: _____

To the Health Care Provider:

Please ensure the medical assessment form is completed legibly and in layman's terms.

Native Addictions Council of Manitoba requires a client to have a complete medical assessment prior to admission.

The client should not require acute medical care at the time of admission to Native Addictions Council of Manitoba/Pritchard House. Diseases are to be under control, especially communicable diseases.

The drug and alcohol treatment programs require a client to be physically and mentally capable of intense group and individual counseling. Participation is expected in all aspects of the program.

Revised March 28, 2013

Medical History:

Vital Signs:

BP: _____ P: _____ R.R: _____ Sp02: _____ RBS: _____

Please indicate whether the client has or had any history of the following:

	Medication	Duration	Prescribing Doctor
Allergies Reaction:			
High Blood Pressure			
High Cholesterol			
Diabetes			
Asthma			
Heart disease/stroke			
Epilepsy/seizure			
Head Injury			
Skin condition			
Scabies, lice, impetigo			
Sexual transmitted infections			
Hepatitis			
HIV			
Pregnancy (EDC)			
Methadone			
Sleeping Disorders			
Other conditions, explain:			

Mental Health/Illness:

Anxiety/panic attacks			
Bipolar Disorder			
Depression			
Schizophrenia			
Suicidal Ideation			
Other conditions, explain:			

Tuberculosis Screening:

Recent contacts to TB: yes ___ no ___

Tuberculin skin test: yes ___ no ___ Documented: yes ___ no ___

Signs and Symptoms of active TB:

Coughing	Yes ___	No ___	Blood in sputum:	Yes ___	No ___
Night sweats:	Yes ___	No ___	Fever:	Yes ___	No ___
Loss of appetite:	Yes ___	No ___	Unexplained weight loss:	Yes ___	No ___

Are you aware of current or recent medical problems which may require follow-up while client is in treatment?
If yes, please explain:

_____

_____

_____

Follow-up appointment date & time:

_____

Name: _____
(Health Care Provider)

Address: _____

City: _____ Province: _____

Postal Code: _____

Telephone: _____

Fax: _____

Office Stamp

_____ _____
(Health Care Provider-Signature) **(Date)**