MIGISI ALCOHOL & DRUG TREATMENT CENTRE

MEDICAL ADMISSION FORM

Information must be completed by a Medical Examiner

Patients Name:	Patients Date of Birth:
Health Card Number:	

Please indicate whether the patient has any history of the following:	
Allergies:	Injectable Drug Use:
Cancer:	Hepatitis A, B, C:
Diabetes:	HIV/AIDS:
Epilepsy:	Vaginal Discharge:
Heart Disease:	Venereal Disease:
Other:	

Tuberculosis (TB) Screen:

Has the client ever had TB? Yes No

Has the applicant had a TB skin test? Yes No

Does the Medical Examiner suspect any concerns? Yes No

Date of test: _____ Test Results:

_____

Chest X-ray (if applicable): Yes No Results: _____

Treatment Provided:

_____

If you are aware of any peculiarity or problems that we should consider in treatment, please provide details: *(Extreme Anxiety, Potential Suicide Tendencies, Depression, etc.)*

Operation and/or Serious Illness

Please give approximate dates, names of physicians or surgeons, medications involved, and results of treatment:

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Psychiatric/Psychologist Services:
Please give approximate dates, treatment facilities, and names of psychiatrist/psychologist:

Please list current medication			
Current Medication	**Prescribed by**	**Date of Prescription**	**Is the client able to refrain for 28 days?**
Attach additional sheet if needed			

Does the physician request that the following applicant receive psychological services? ***YES / NO***

If so, please print name of client.

_____ will be receiving treatment for alcohol and/or drug abuse at Migisi Treatment
(Name of Client)
Centre. He/she may receive additional treatment by a chartered psychologist. We are requesting that you refer him/her for assessment and further consultation.

Name of Physician/Nurse: _____

Office Address: _____

Office Telephone Number: _____

Date of Medical: _____

Physician/Nurse Signature: _____

Office Stamp: