CENTRE JUBILEE CENTRE
MEDICAL EXAMINATION FORM

CONFIDENTIAL

Instructions to Clients: Please complete sections A and B. Book an appointment with a Physician/Nurse and ask that the remaining sections of this form be completed as soon as possible. Return the completed form to Jubilee Centre promptly, in order that your request for admission is processed without undue delay. The information provided on this form is subject to the Centre's CLIENT CONFIDENTIALITY POLICY and will be used in connection with your request for admission and eventual treatment planning, if admitted. Jubilee Centre will not assume responsibility for any costs associated with the completion of this form. Thank-you.

A. CLIENT IDENTIFICATION

FULL NAME_____ HEALTH CARD NO._____

DATE OF BIRTH_____ ADDRESS_____

POSTAL CODE_____ TEL NO. _____ ADMISSION DATE_____

PHYSICAN'S NAME_____ TEL NO. _____

ADDRESS_____ POSTAL CODE_____

B. AUTHORIZATION TO PHYSICIAN/NURSE & JUBILEE CENTRE

I, _____, above named patient/client, hereby authorize reciprocal release of information contained herein and discharge summary between the signing Physician/Nurse and Jubilee Centre. I consent to the use of such information in connection with my request for admission and eventual treatment at Jubilee Centre and possible follow-up with the signing Physician/Nurse.THIS CONSENT IS VALID FOR A PERIOD OF (90) NINETY DAYS FROM THE DATE OF SIGNING.

☐ ***Instructions to Physician/Nurse: Please complete sections C through F and return the signed form to the patient, unless you have agreed to forward the form to Jubilee Centre on the patient's behalf. If you wish to receive a discharge summary, please place a checkmark in the box. Thank-you.***

C. MEDICAL HISTORY OF SUBSTANCE USE

Substance(s) used: _____

_____

Length of substance(s) use: _____

Cessation of substance(s) use: _____ Associated symptoms/problems: D.Ts_____

Tremors____ Seizures_____ Hallucinations_____ Lung disease_____ Liver disease____

HIV infection risk factors____ Previous substance abuse treatment; place and date:_____

_____

_____

D. OTHER CURRENT MEDICAL/PSYCHIATRIC HISTORY

E. PAST MEDICAL HISTORY

TB; Active____ Dormant____ STDs_____ HIV_____
Smoker_____ Allergies_____
Hep. A B C_____ Active: yes_____no_____ Current medication(s) _____

Other: _____

F. EXAMINATION

General: B/P_____ Wt._____ Other vitals:_____
Head and Neck: _____

Chest: _____
CVS: S_____ S _____
Murmur: _____
G.U. _____
Abdomen: _____
CNS: _____
Skin: _____
Ext: _____

Impressions: _____

Further tests planned: ***Place checkmark in appropriate box(es), specifying tests.***

- ☐ prior to attending Jubilee Centre: _____
- ☐ while at Jubilee Centre: _____
- ☐ after leaving Jubilee Centre: _____

Medications: _____

Recommendations: ***Place checkmark in appropriate box(es) and elaborate if necessary.***

- ☐ Full participation at Jubilee Centre: (when)_____
- ☐ Referred elsewhere: (specify)_____
- ☐ Other: (specify)_____

_____/_____
Physician/Nurse Signature Date

_____
Physician/Nurse Name & Tel. No.
(Please print clearly)

CENTRE JUBILEE CENTRE
Psychoactive Medication Tracking Sheet
APPENDIX 'C'

Client Name: _____ D.O.B.: _____ Date: _____

ONLY ONE ENTRY PER ROW

Med. Name & Label Instructions	Physician Name & Phone No.	Pharmacy Name & Phone No.	Dosage (Strength)	Form (pill, liquid, inject., ointment, etc...)	Time(s) taken per day	Date First Prescri-bed	Date Last Refilled	Amount Refilled (# of pills, milliliters, etc.)	Amount Remain-ing	Reason for Use	For Office Use Only (Do not write in coloumn)

NOTE TO CLIENT or REFERRAL SOURCE: This sheet is to be completed and returned to Jubilee Centre prior to the admission date, if the client plans to enter residential treatment while taking any of the following medications: 1. OPOIDS (sometimes referred to as NARCOTICS commonly prescribed for pain, 2. CNS DEPRESSANTS including Barbiturates commonly prescribed for their sedative, hypnotic, anaesthetic, and anticonvulsant effects and Benzodiazepines commonly prescribed to produce sedation and sleep, relieve anxiety and muscle spasms and to prevent seizures, 3. CNS STIMULANTS sometimes prescribed for narcolepsy, ADHD, obesity and asthma etc..., 4. ANTIDEPRESSANTS and ANTIPSYCHOTICS.

IMPORTANT: Clients arriving with unexplained discrepancies may be refused admission.

CENTRE JUBILEE CENTRE
(OTC) Over-the-Counter Medication Tracking Sheet
APPENCIX 'D'

Client Name: _____ **D.O.B.:** _____ **Date:** _____

ONLY ONE ENTRY PER ROW

Med. Name and Label Instructions	Dosage (strength)	Form (pill, liquid, inject., ointment, etc…)	Time(s) taken per day	Date first purchased	Date last purchased	Amount remaining (# of pills, milliliters etc…)	Reason for use	For Office Use Only (Do not Write in This Space)

NOTE TO CLIENT or REFERRAL SOURCE: This sheet is to be completed and returned to Jubilee Centre prior to the admission date, if the client plans to enter residential treatment while taking any of the following medications: 1. ANALGESICS, 2. COUGH/COLD and ALLERGY PREPARATIONS, 3. LAXATIVES, 4. APPETITE SUPPRESANTS/DIET AIDS, 5. SLEEPING AIDS and 6. ANTI-NAUZEA/ANTI-EMETIC AGENTS.

IMPORTANT: Clients arriving with unexplained discrepancies may be refused admission.