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 from 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:____________

PHYSICIAN'S NAME:__________________________ TEL. NO.:______________

ADDRESS:__________________________________ POSTAL CODE:____________

B. AUTHORIZATION TO PHYSICIAN/NURSE & JUBILEE CENTRE

I,______________________ above named patient/client, hereby authorized 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/Nurses: 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 - Yes ☐ No ☐ Allergies:______________

Hep. A B C:__________ Active: Yes ☐ No ☐ Current medication(s):______________

____

____

Other:____

F. EXAMINATION

General: B/P:__________ Wt.:__________ Other vitals:______________

Head and Neck:____

____

Chest:______________________

____

____

Abdomen:______________________

____

____

CVS: S__________ S__________

Murmur:______________________

G.U.:______________________

CNS:______________________

Skin:______________________

Ext.:______________________

Impressions:____

____

____

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

☐ 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)