Pelican High Peak Youth Healing Lodge
70 Wellington Street
Sioux Lookout, ON P8T 1E1

Ka-Na-Chi-Ih Specialized Solvent Abuse Treatment Centre
1700 Dease Street
Thunder Bay, ON P7C 5H4

Wakenagun Youth Healing Lodge
5310 Highway 101 West
Timmins, ON P4R 0B5

CLEAR / RESET FORM

PART 2 – MEDICAL ASSESSMENT

To be completed by a Health Professional (i.e., Physician, Nurse Practitioner, Nurse) prior to admittance into the treatment program.

Please complete this section in a CLEAR manner.

PATIENT'S NAME: _____

D.O.B (mm/dd/yyyy): _____ BAND NAME: _____

HEALTH CARD #: _____ STATUS CARD #: _____

DATE OF EXAM: _____

A. MEDICAL HISTORY (Please explain any 'YES' responses in Section B)

CONDITION	DIAGNOSED / HISTORY OF:	
	YES and DATE	NO
Anemia	◯	◯
Back Injury / Problems	◯	◯
Brain Injury	◯	◯
Cardiovascular Problems	◯	◯
Cognition Problems	◯	◯
Chicken Pox	◯	◯
Dental Pain (tender jaw, toothache, temperature sensitivities, other – please specify): >	◯	◯
Disease / Injury of Bones of Joints	◯	◯
Diabetes / Hypoglycemia (please specify): >	◯	◯
Ear, Nose, Throat Problems	◯	◯
Eating Disorders	◯	◯
Eye Problems	◯	◯
Epilepsy	◯	◯
Fainting	◯	◯

CONDITION	DIAGNOSED / HISTORY OF:	
	YES and DATE	NO
Feet Problems (orthotics, foot pain, toenail pain, other – please specify): >	◯	◯
Hallucinations / Delusions	◯	◯
Heart Problems	◯	◯
Hepatitis (A, B or C, please indicate): >	◯	◯
Respiratory Problems	◯	◯
Gastrointestinal Problems	◯	◯
Pancreatic Problems	◯	◯
Kidney or Urinary Problems	◯	◯
Learning Disability	◯	◯
Tuberculosis	◯	◯
Chronic Pain	◯	◯
Sleep Disorder	◯	◯
Withdrawal Symptoms (seizures, other – please indicate): >	◯	◯
Mental Health (please indicate): >	◯	◯
HIV / AIDS	◯	◯
Sexually Transmitted Disease (please indicate): >	◯	◯
Medical Confirmation of Pregnancy (if applicable, please indicate # of weeks): >	◯	◯
Allergies (drug, food, other – please indicate): >	◯	◯
Tobacco Use	◯	◯
Skin Conditions	◯	◯
Self-Harm (cutting, burning, other)	◯	◯
Suicidal Ideation / Suicide Attempt(s)	◯	◯
Surgery (please indicate): >	◯	◯

Other: > >	○ ○	○ ○

B. PHYSICAL EXAMINATION

HEIGHT: _____ WEIGHT: _____ BLOOD PRESSURE: _____ PULSE: _____

Please indicate if the following areas listed below are observed to have 'No Concerns' during the physical examination:

AREA	NO CONCERNS	AREA	NO CONCERNS
Cardiovascular	☐	Musculoskeletal System	☐
Cognition	☐	Neuropsychiatry	☐
Ears, Nose, Throat (system review)	☐	Lymph Nodes	☐
Eyes	☐	Respiratory	☐
Hygiene (standard)	☐	Skin	☐
Mental Health	☐	Other:	☐

If 'YES' was indicated for any areas in Section A or any areas during Section B were observed to have concerns, please explain:

C. CURRENT PRESCRIPTON MEDICATIONS

Please list current medications (including prescription medications and over-the-counter drugs) you are aware the applicant is taking. Please note: Mood altering medications must be prescribed and monitored by a psychiatrist for management of a mental illness. If more space is required, please attach a current medication list with the application.

MEDICATION	DOSE	FREQUENCY	START DATE	END DATE	INDICATION (USED FOR?)

Reminder to Health Professional: For the client's safety and well-being while at the Healing Lodge, please ensure that all prescription medication(s) are transferred to the appropriate pharmacy of choice listed below **one week prior** to the admission date.

HEALING LODGE	PHARMACY OF CHOICE	PHARMACY CONTACT INFORMATION
Ka-Na-Chi-Hih	Janzen's Pharmacy – The Link 300 Lillie St. N., Thunder Bay, ON.	Phone: (807) 344-0405 Fax: (807) 344-0483
Wakenagun	Shoppers Drug Mart 227 Algonquin Blvd. W., Timmins, ON.	Phone: (705) 264-4311 Fax: (705) 264-0199
Pelican High Peak	Sioux Lookout Remedy's Rx 75 King St., Sioux Lookout, ON.	Phone: (807) 737-4998 Fax: (807) 737-7174

IN YOUR OPINION, IS THIS CLIENT MEDICALLY STABLE AND APPROPRIATE FOR ADMISSION TO A RESIDENTIAL ADDICTION TREATMENT PROGRAM? ◯ YES ◯ NO

In the past 6 months, has the client been using the medication appropriately? ◯ YES ◯ NO ◯ N/A

If NO, please explain: _____

_____

_____

IS THE CLIENT VACCINATED FOR COVID-19?

◯ NO ◯ YES (1st shot only) ◯ YES (2 shots only) ◯ YES (2 shots plus booster(s))

IS THE PROOF OF VACCINATION ATTACHED TO THE ADMISSION FORM? ◯ YES ◯ NO

D. OVER-THE-COUNTER MEDICATIONS & TRADITIONAL MEDICINES

Please indicate if there are any concerns or side effects that we need to be made aware of with this client regarding the use of over-the-counter medications and traditional medicines if taken with current prescription medication(s):

OVER-THE-COUNTER MEDICATIONS	CONCERNS OR SIDE EFFECTS
Tylenol	
Advil	
Cold Medication	
Melatonin	
Other: >	
TRADITIONAL MEDICINES	**CONCERNS OR SIDE EFFECTS**
Cedar Tea	
Labrador Tea	
Bear Grease (topical)	
Other: >	

E. HEALTH PROFESSIONAL'S INFORMATION

HEALTH PROFESSIONAL'S FULL NAME (print): _____

JOB TITLE: _____ DATE: _____

ADDRESS: _____

PROVINCE/TERRITORY: _____ POSTAL CODE: _____

PHONE: _____ FAX: _____

EMAIL: _____

HEALTH PROFESSIONAL'S SIGNATURE: _____

OTHER (i.e., psychiatrist or specialist relevant to this admission): _____

PHONE: _____ FAX: _____

EMAIL: _____

F. CLIENT CONSENT TO RELEASE INFORMATION

I hereby authorize the above-named health professional to release the information to the appropriate Healing Lodge and relevant staff, as required, to assess my suitability for acceptance and admittance into the treatment program.

_____ _____

PARENT/LEGAL GUARDIAN/CLIENT SIGNATURE DATE