

Section 1 of 2 – Consent to release Client Medical Information

I (parent), _____, hereby request and permit my physician to release any medical facts and assessments about my child to Kackaamin Family Development Centre and the referring agency listed above.

Child Patient's Name: _____

Signature of Parent: _____ **Date:** _____

N.B. for the attending Physician:

Some Child Clients are required to have complete physical examination prior to admission. They should not require any acute medical care at the time of admission to Kackaamin. All communicable diseases should be in remission and properly medicated.

KFDC requires the above client to be medically assessed as a potential participant in our six week residential substance misuse treatment program. The KFDC program is designed to help people acknowledge that substance misuse has interfered with their lives. Please assess if they are physically and mentally ready to participate in a program of that offers counselling and educational workshops.

Section 2 of 2 – Pre admission Medical Information

(To Be Completed by the Physician / RN / CHN)

Patient's Name: _____ Date of Birth: _____

Care Card Number: _____ Status Number: _____

Physical Exam – medical information

1. Known Allergies: Yes No

If "yes", what is the Patient allergic to? _____

N.B. the patient must bring their own epipen if they are apitoxin allergic. Please prescribe one if needed.

2. Please check all issues that apply.

E.E.N.T. Chronic Cough F.A.S.D. Cancer Pregnant Arthritis Asthma

Client's Name: _____

- G.I. Seizures Freq U.T.I. Neurological disorder
 Epilepsy Date of last seizure _____
 HIV / AIDS
 S.T.I. Type _____

Hepatitis *(please circle any that apply)* A B C

Sensory Impairment *(please circle any that apply)* vision hearing olfactory

Does the patient have any other type of special need (i.e. learning disability, difficulties with reading, writing)
 Yes No

Please describe: _____

Tuberculosis ~ TB *(please circle any that apply)* Active Dormant

(The patient must have had a T.B. Test in the last 12 months) Date _____

N.B. If the TB skin test is positive and the results measure larger than 10mm, a subsequent TB chest X-ray must be performed.

3. Does the patient have a heart condition? *(Please name the condition)* _____

What is the patient's Blood Pressure? _____

4. Does the patient have an infestation of any kind (i.e. lice, scabies)? _____

5. Diabetes: Yes No

Does patient manage blood glucose levels with: Pills Insulin Injection?

What are the target blood glucose levels? _____

6. Has the patient ever been diagnosed with a Mental Health Problem? Yes No

If yes when: _____ (date) Specify the diagnosis _____

Name of Psychiatrist/Psychologist: _____ Phone: _____

7. Does the patient have allergies to any medications? _____

8. Are you aware of current or recent medical problems which may require follow-up while the patient is in treatment at KFDC? Yes No

Client's Name: _____

9. Does the patient have a dual diagnosis or co-morbidity? Yes No

If "Yes" please list the illnesses, date of diagnosis, medication prescribed and any information that you deem pertinent.

10. Are the child or Youth's Immunizations currently up to date? Yes No

Explain: _____

N.B. Please attach a copy of the child or youth's current Immunization record.

Name: _____
(Physician / RN / CHN's name)

Address: _____

City: _____

Postal Code: _____

Telephone: _____

Fax: _____

OFFICE STAMP

(Physician / RN / CHN's Signature)

(Date)

Client's Name: _____