Native Addictions Council of Manitoba
160 Salter St Winnipeg, MB R2W4K1
Phone (204) 586-8395 Fax (204) 589-3921

MEDICAL ASSESSMENT

(To be completed by MD, NP OR RN)

Personal Identification:

First Name: _____ Last Name: _____

Date of Birth: Year _____ Month_____ Day_____

Gender: *(check which applies)*

- ☐ Female
- ☐ Male
- ☐ Two Spirit
- ☐ Other _____

Provincial Heath Card Number: _____

Treaty Number: _____

Informed Consent Must Be Completed with Applicant:

I, (applicant name) _____ give permission to _____

to release medical facts and assessment about myself to Native Addictions Council of Manitoba. The photocopy of my signature on this form is as valid as the original.

Applicant signature _____ Date: _____

To the Health Care Provider:

Ensure the medial assessment form is completed legibly and in layman's terms.

Native Addictions Council of Manitoba requires an applicant to have a complete medical assessment prior to admission

The applicant should not require acute medical care at the time of admission to Native Addictions Council of Manitoba. Diseases are to be under control, especially communicable diseases.

The drug and alcohol treatment programs require a participant to be physically and mentally capable of intense group and individual counselling. Participation is expected in all aspects of the program.

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Medical History:

Please indicate whether the applicant has or had any history of the following:

	Medication	Duration	Prescribing Doctor
Allergies/ Reactions:			
High Blood Pressure			
High Cholesterol			
Diabetes			
Asthma			
Heart disease/Stroke			
Head Injury			
Skin Condition			
Scabies, Lice, Impetigo			
Sexual Transmitted Infections			
Hepatitis			
HIV			
Pregnancy (EDC)			
Methadone			
Sleeping Disorders			
Other Conditions, explain			

Mental Health/Illness:

Anxiety/Panic Attacks			
Bipolar Disorder			
Depression			
Schizophrenia			
Suicidal Ideation			
Other Conditions, explain			

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Tuberculosis Screening:

Recent contacts to TB: Yes _____ No _____

Tuberculin Skin Test Yes _____ No _____

Signs and Symptoms of active TB:

Coughing	Yes ____	No _____	Blood in Sputum:	Yes _____	No _____
Night Sweats	Yes ____	No _____	Fever:	Yes _____	No _____
Loss of Appetite:	Yes ____	No _____	Unexplained weight loss	Yes _____	No _____

Are you aware of current or recent medical problems which may require follow-up while client is in treatment?
If yes, please explain:

_____

_____

_____

Follow-up appointment date & time:

_____

Name: _____
(Health Care Provider)

Address: _____

City: _____ Province: _____

Telephone: _____

Fax: _____

Office Stamp

_____ _____
(Health Care Provider Signature) (Date)

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