Last Name	
First Name	
PHN #	Date of Birth

Medical Assessment

Date of Examination (yyyy-mm-dd)			
Sex	Height	Weight	Blood Pressure

Allergies

❑ No Known Allergies

❑ Drug Allergies : _____

❑ Non-Drug Allergies: _____

History of Substance Use	
❑ Alcohol:_____ ❑ Opioids:_____ ❑ Stimulants :_____ ❑ Other: _____	Length of Substance Use: Cessation of Substance Use:

Associated symptoms/problems

❑ Delirium Tremens	❑ Seizures	❑ Lung Disease	❑ HIV Infection Risk Factors
❑ Tremors	❑ Hallucinations	❑ Liver Disease	

Physical Findings			
Is there evidence of past or present abnormality of:	**No** ✓	**Yes** ✓	If ***Yes***, please describe. (Please attach additional information if required.
Head and Neck			
Cardiovascular System			
Respiratory System			
Gastrointestinal System			
Skin, Lymph Nodes, Breasts			
Musculoskeletal System			
Nervous System			
Genitourinary System			
Mental Health			
Infectious Diseases			
Cognitive Status			

Diagnosis
1.
2.
3.
4.
5.

Past Medical History	
❑ Tuberculosis: ❑ Active ❑ Dormant ❑ Sexually Transmitted Infections :_____ ❑ Human Immunodeficiency Virus:_____ ❑ Hepatitis : _____	Cigarette smoker: ❑ Yes ❑ No Amount of cigarettes per day: _____ Allergies:

Medication	**Dosage**	**Frequency**	**Route**	**Start Date (yyyy-mm-dd)**

In your opinion, is this patient MEDICALLY stable & appropriate for admission to Residential Addiction Treatment?

❑ Yes ❑ No ❑ Further investigation is required: _____

Name and Address of Physician/Nurse completing Application	
Name:	
Address:	Phone Number:
Signature:	

PATIENT'S RELEASE OF CONFIDENTIALITY: I herby authorize the 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.

Patient's Signature: _____ Date: _____