ACTION NORTH RECOVERY CENTRE

Box 872 * High Level, Alberta * T0H 1Z0 * Telephone (780) 926-3113 * FAX (780) 926-2060

CONFIDENTIAL MEDICAL FORM

TO BE COMPLETED BY A DOCTOR AND/OR REGISTERED NURSE

Client Name: ____
(Surname) (Given Names)

Address: ____
(Street/Box) (City) (Province/Territory) (Postal Code)

HC#: ____________________ Age: __________ DOB: ____________________
(MM/DD/YY)

Doctor's and/or Registered Nurse's name(s) ______________________________

Address: ____
(Street/Box) (City) (Province/Territory) (Postal Code)

Phone No.: ____________________ FAX: ____________________

Indicates **YES** or **NO** whether patient has any history of:

Allergies: ________ Cancer: ________ Diabetes: ________ Epilepsy: ________ Heart Disease: ________

Rheumatic Fever: ________ T.B.: ________ Vaginal Discharge: ________ STD'S.: ________

If Yes to any of the above, please give details:

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Operations or Serious Illness:
Please give approximate dates, names of physicians or surgeons, medication involved, and results of the treatment.

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Psychiatric Treatment:
Please give approximate dates, treatment facilities, names of psychiatrists, and results of the treatment.

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Current Medications:

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Physical Examination:
Indicate any physical peculiarity or problem that should be taken into account when medically treating the applicant at Action North Recovery Centre, High Level, Alberta.

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General:
If you are aware of any peculiarity or problem (extreme anxiety, suicide attempts, depression, etc...) that should be taken into account in treating this patient, please give details.

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Having completed the applicant's physical examination, I certify his/her medical suitability for attendance at Action North Recovery Centre, High Level, Alberta.

______________________________ ______________________________M.D.
Date Signature