Dilico
Anishinabek Family Care

ADMISSION MEDICAL ASSESSMENT
Family Healing Wellness Centre
Mental Health and Addictions Services

Instructions: To be completed by a Physician, Nurse Practitioner or Nursing Station. Note: This client is registered to attend a residential family healing centre. The treatment is an intensive 28-day program that prioritizes dealing with mental health and addictions issues.

Client's Name:	Date of Birth (mm/dd/yyyy):
Health Card #:	Blood Pressure:
Vision:	Hearing:
Height:	Weight:
Chest:	Heart:
Abdomen:	Extremities:
Allergies:	

Present Health Problems:

_____

_____

Past Health Problems:

_____

_____

Current Medication and Dosage:

_____

_____

Is a special diet indicated?

YES ☐ NO ☐ *If yes, explain* _____

Is this client free of communicable diseases?

YES ☐ NO ☐ *If no, explain* _____

Is this client able to participate in physical recreation?

YES ☐ NO ☐
WITH SOME RESTRICTIONS ☐ *Explain* _____

Does this client have any mobility restrictions?

YES ☐ NO ☐ *If yes, explain* _____

Are you aware of any difficulties that we should consider in treatment (i.e., extreme anxiety, suicidal thoughts, depression, etc.)? Please provide details:

_____

_____

Additional comments or opinions:

_____

_____

_____

_____ _____

Physician's Name (please print) Telephone Number

_____ _____

Physician's Signature Date

Tuberculosis (TB) Skin Test Form

Client Information:

First/Last Name: _____

Clinic Information:

Clinic Name: _____ Address: _____

Phone: _____

One-Step TB Skin Test Administration:

Date Given: _____ Signature/Title: _____

Location: (Circle One) Left Arm Right Arm

Date Read: _____ Signature/Title: _____

Results: _____ mm Interpretation: (Circle One) Negative Positive

***Results must be read within 48 hours by trained professional.**

Action Plan:

_____

_____

_____

_____

_____ _____

Physician's Name (please print) Telephone Number

_____ _____

Physician's Signature Date