SUNRISE

Native Addictions Services Society
1231 - 34th Avenue N.E., Calgary, AB T2E 6N4
(P) 403-261-7921 (F) 403-261-7945 Administration
(F) 403-269-5578 Client Admissions
(E) nasgeneral@nass.ca

Confidential Inpatient Treatment Medical Form

It is a requirement of Sunrise Native Addictions Services Society that any client seeking admission to this facility must present a recent medical examination. This form will need to be filled out by a Doctor/RN and included with the client's application for admission.

Applicant's Name: _____

Alberta Health Care Number: _____

Client's Consent to Release Information:

I, _____ (client's name) hereby consent to the release of my medical assessment contained in this questionnaire to SUNRISE – Native Addictions Services Society.

_____ _____
Client or Applicant's Signature: Date:

Doctor/RN Name: _____ Phone Number: _____

Address: _____

Are you the applicant's regular Doctor: YES ☐No ☐

Certain medical conditions and/or surgeries may restrict the client's participation in the treatment program. Please indicate whether this applicant has a history of any of the following:

Cancer		**Sexually Transmitted Disease**	
Epilepsy		**Heart Disease**	
Diabetes		**Tuberculosis**	
Allergies		**Respiratory Problems**	
Rheumatic Fever		**Hallucinations**	
Visual Problems		**Audio Problems**	
Alcohol/Drug Related Seizures		**Arthritis**	
Hepatitis/Liver Disease		**Kidney Disease**	
Pressure Ulcers		**VTE (Venous thromboembolism)**	
Skin or Wound Care Necessary		**Recent Surgery**	
Other: please specify			

Please give details of any of the items checked above. (Use the other side of this page, if necessary)

Tuberculosis Symptom Inquiry – does this applicant present with any of the following symptoms:

☐ cough ≥ 3 weeks (productive) ☐ fever

☐ night sweats ☐ weight loss

☐ fatigue ☐ hemoptysis

If symptoms suggest active TB disease, chest x-ray and sputum samples for AFB and culture are recommended and possible referral to Tuberculosis Services 403-944-7660

Influenza Symptom Inquiry – Does this applicant present with any of the following symptoms:

☐ symptoms of fever ☐cough ☐ runny nose

☐ sore throat ☐ body aches ☐ fatigue

☐lack of appetite ☐ diarrhea ☐ vomiting

If symptoms suggest active influenza please direct the client for proper treatment. Clients must be symptom free to attend our Inpatient Treatment Program.

Psychological/psychiatric conditions might interfere with participation in the treatment program. Are you aware of any peculiarity or problems (i.e.: extreme anxiety, psychosis, depression, suicide attempts, etc.) that should be taken into account during treatment. Please detail:

Please List all Drug and Food Allergies:

Current Medications	Prescribed by	Date Prescribed	Duration and Reason Prescribed

If the client needs a refill for any of their medication it will assist the client and SUNRISE if they come to treatment with a prescription or all of their needed medications. They may not be allowed to attend treatment should they not arrive with all their medications or a prescription in hand.

I certify the above to be true to the best of my knowledge:

Doctor/RN Signature **Date**