



**MEDICAL ASSESSMENT FORM
YOUTH TREATMENT CENTRE**

**Mental Health and
Addictions
Medical Assessment Form**

First Name: _____

Last Name: _____

Date of Birth: _____

CRMS #: _____

MCP/HCN #: _____

Physician/NP Name: _____

Physician/NP Address: _____

Physician/NP Telephone #: _____

Physician/NP Facsimile #: _____

Allergies: _____

Diagnosis

Diagnosed by

Diagnosis Date

CURRENT MEDICATIONS (include OTC and Supplements)

Current Drug

Prescribed Dosage

Prescribed for

Brief Medical History (including mental health issues):

Past Medical History: _____

Past Social History: _____

OB/GYN: _____

Mental Health: _____

Vital Signs: Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

Physical Examination:

Are immunizations up to date?

☐ Yes

☐ No

Could the youth be pregnant?

☐ Yes

☐ No

Does the youth have diabetes?

☐ Yes

☐ No

Does the youth epileptic?

☐ Yes

☐ No

Does the youth engage in self-harm behavior?

☐ Yes

☐ No

Is the youth currently suicidal?

☐ Yes

☐ No

Has youth had past suicidal ideation?

☐ Yes

☐ No

Has youth had past suicide attempts?

☐ Yes

☐ No

To your knowledge, does the youth have any of the following conditions?

Skin rash

☐ Yes

☐ No

Scabies

☐ Yes

☐ No

Plantar Warts

☐ Yes

☐ No

Athlete's foot

☐ Yes

☐ No

Tuberculosis

☐ Yes

☐ No

Are you aware of any other communicable conditions the youth has which could affect the health of other residents or staff in a group setting? ☐ Yes ☐ No

Explain: _____

Do you suggest any medical follow-up while the youth is at the Youth Treatment Centre?

Problem: _____ Suggested Follow-Up: _____

In your opinion, is the youth able to participate in the treatment program (i.e., able to concentrate, take part in therapeutic activities)? Yes ☐ No ☐

Comments: _____

Does the youth have any physical restrictions? Yes ☐ No ☐

Explain: _____

Does the youth use tobacco products? Yes ☐ No ☐

If yes, is Nicotine Replacement Therapy safe for this youth (i.e. gum, patch)?

Yes ☐ No ☐

Comments: _____

Are there any medical concerns not mentioned on this form in which Youth Treatment Centre staff should be aware? Yes ☐ No ☐

Comments: _____

Date: _____

Signature of Physician/Nurse Practitioner

Signature of Youth and Parent/Guardian