Mental Health and Addictions
Youth Treatment Centre

Medical Assessment For Referral

Name: ____________________

HCN #: ____________________

Date of Birth: (DD/MONTH/YYY)

Date: DD/MONTH/YYYY   CRMS #: ____________________

This youth is referred to the Youth Treatment Center for Youth with Complex Mental Health Needs (Paradise), where he/she will participate in an inpatient treatment program.

1. PERSONAL INFORMATION			
Phone #:		Address:	
Primary Physician/NP:		Phone #:	
Allergies:			

2. CURRENT MEDICATIONS (please include OTC and Supplements)		
Medication	Dosage	Reason for Prescription

If applicable, is Nicotine Replacement Therapy safe for this youth? ☐ Yes ☐ No ☐ N/A

3. BRIEF MEDICAL / SOCIAL HISTORY
Past Medical History/Mental Health Concerns/Substance Use:
Past Social History:
Past Family History/Mental Health Concerns/Substance Use:

SIGNATURE: ____________________ PRINT: ____________________ DATE: dd/mm/year

Eastern Health acknowledges and respects the privacy of individuals. This personal information is being collected under the authority of Sections 32 and 33 of the *Access to Information and Protection of Privacy Act.* And will be used for processing your request for Mental Health and Addictions Services. Please direct any questions about this collection to: Privacy Officer, Eastern Health, Quality and Risk Management, 12th Floor Southcott Hall, 777-8025.

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4. PHYSICAL EXAM					
Height:	Weight:	Blood Pressure:		Pulse:	
Gravida:	Term:	Premature:	Abortuses:	Living:	N/A: ☐

	N	ABN		N	ABN
General Appearance:	☐	☐	Lungs	☐	☐
Head	☐	☐	Abdomen	☐	☐
Eyes	☐	☐	GI/GU	☐	☐
Ears	☐	☐	MSK	☐	☐
Nose	☐	☐	Skin	☐	☐
Throat	☐	☐	Neurological	☐	☐
Neck	☐	☐	Psychiatric	☐	☐
Cardiac	☐	☐			

Comments regarding physical exam:

5. COMMUNICABLE DISEASE:

Are immunizations up to date: ☐ Yes ☐ No ☐ Unknown

To your knowledge, does the youth have any of the following:

	Yes	No		Yes	No
HIV	☐	☐	Strep Throat	☐	☐
Hepatitis	☐	☐	Scarlet Fever	☐	☐
Turberculosis	☐	☐	Mononeucleosis	☐	☐
Diptheria	☐	☐	Influenza	☐	☐
Pertussis	☐	☐	Impetigo	☐	☐
Varicella	☐	☐	Infestations	☐	☐
Menengitis	☐	☐	STIs	☐	☐
Measles	☐	☐	Conujunctivitis	☐	☐
Mumps	☐	☐	Enteric Illness	☐	☐
Rubella	☐	☐	Tinea Coporsis/Pedis	☐	☐
Plantar Warts	☐	☐	Other:		

SIGNATURE: ____________________ PRINT: ____________________ DATE: DD/MONTH/YYYY

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Comments regarding communicable diseases:

6. MEDICAL FOLLOW-UP	
Do you suggest any medical follow-up while the youth is at the Youth Treatment Centre?	
Illness / Issue / Concern:	Suggested Follow-up:

		(DD/MONTH/YYY)
Signature of Physician / Nurse Practitioner	Print	Date

		(DD/MONTH/YYY)
Signature of Youth	Print	Date

SIGNATURE: ______________ PRINT: ______________ DATE: DD/MONTH/YYYY

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