Wolastoqewiyik Healing Lodge

13309 Rt. 105 Tobique First Nation E7H 5K1

Tel: (506) 273-5403 Fax: (506) 273-4286

Medical Clearance Form

Surname: ______________________________First Name: _________________________________

Date of Birth: __________________________ Sex: M_____ F_____

Address: ___________________________City ___________________________Province __________

Postal Code:_________________ Phone: Home___________________ Cell____________________

Medicare #_______________________________Band/Registration # __________________________

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I, _______________________________hereby request and consent for my Prescribing Physician/Nurse Practitioner to release pertinent facts and any/all clinical assessments regarding my medical care and health history, to Wolastoqewiyik Healing Lodge, for the purposes and intents of admission to addictions rehabilitation and treatment. This photo copy of my signature is as valid as the original.

Client Signature _____________________________________ Date:___________________________

Witness:____ Date:______________________________

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Medical History:
Please answer the questions honestly and to the best of your knowledge. It is important the Physician and/or Nurse Practitioner add or comment on any of the areas as needed.

Identify current and past health conditions: (attach another page if necessary)

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Do you have a history of any of the following (Please Check):

Diabetes: ____Y ____N (If Yes, circle) **Type 1 or Type 2** List Medication____________________

Hypertension: ____y ____N blood pressure reading ____

Heart Conditions: ____Y ____N (If yes, please explain) ___________________________________

Headaches/Migraines: ____Y _____N

Hepatitis A/B/C: ____Y ____N (Circle one) List any treatment received ______________________

HIV/AIDS: ____Y ____N (If yes, list any treatment received) ________________________________

IV Drugs: ____Y ____N (If yes, please explain)____

Seizures: ____Y ____N (If yes, please indicate last episode ________________________________

Arthritis: ____Y ____N

Epilepsy: ____Y ____N (If yes, when was the last episode?)_________________________________

Tuberculosis ____Y ____N (If yes, date of last x-ray & results) _____________________________

Asthma: ____Y ____N

Smoker: ____Y ____N (if yes, do you plan to quit?) ____Y ____N

Any chance that you may be pregnant? ____Y ____N

As a part of our healing journey at the Wolastoqewiyik Healing Lodge we engage in weekly Sweat Lodge ceremonies. These ceremonies involve long periods of sitting on the ground and very high heated temperatures. Do you have any physical or underlying medical condition that would prevent you from participating in the sweat lodge ceremony? (If yes, please explain)

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Is a Special diet required? (If yes, please explain):

____

____

Have you received any of these immunizations? (Please check):

Influenza :____Y ____N (If yes,date) ____________

Tetanus: ____Y ____N (If yes,date) _____________

Pneumococcal: ____Y ____N (If yes,date) _____________

Hepatitis: ____Y ____N (If yes,date) _____________

Allergies (Please name and describe reaction):

____Reaction______________________________

____Reaction______________________________

____Reaction______________________________

Are you required to carry an Epi-Pen for any of these allergies? ____Y ____N

(Please bring the Epi-Pen with you)

Please check if you have been diagnosed with any of these Mental Health issues:

Anxiety ____Y ____N Bipolar ____Y ____N

Depression ____Y ____N Borderline ____Y ____N

Autism ____Y ____N ADHD ____Y ____N

Other (Please describe) ____

Have you ever received treatment? Explain ____

____

Are you currently on medication for a MH diagnosis? ____Y ____N

(include on Medication List below)

Have you ever suffered from any of the following:

Withdrawal Seizures: ____Y ____N Delirium Tremors: ____Y ____N

Audio Hallucinations: ____Y ____N Visual Hallucinations: ____Y ____N

(If yes, were these treated? Please explain)

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____

Is there any physical limitations that would prevent you from participating in an exercise/walking program? ____Y ____N (If yes, please explain) _______________________

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Are you a client of a Methadone Program?: ____Y ____N (If yes, please complete the following):

Prescribing Physician: _______________________________Phone#____________________

Date program started: _____________________

Dosage: ____________________ Duration on current Dosage:___________________________

Is this dosage stable for you? ____________________________________

Pharmacy ___________________________________ Phone# _________________________

Please note that the dosage cannot be changed while in treatment at WHL.

Medication List

Current Medication	Dose/Frequency	Date Prescribed	Purpose

*** Attach a page, if additional space is required for medications.****

Name of Pharmacy _________________________________ Phone# ____________________________

Please provide a list of current medications from your Pharmacy.

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This Medical Clearance form must be signed by your Prescribing Physician or Prescribing Nurse Practitioner, when medications are prescribed. If there are no medications prescribed then the Primary Care Provider can sign this form.

I hereby certify that I have thoroughly examined ____________________as required, and state that this individual is free from communicable disease, stabilized and is physically, mentally, emotionally and willingly able to undergo the treatment in the five week addictions program offered at the Wolastoqewiyik Healing Lodge at Tobique First Nation.

Signature: ____

Printed Name: ____

Date: _______________________________ Phone#: ____