



# The 2<sup>nd</sup> Floor Women's Recovery Centre Referral Medical Assessment

This form must be completed by a Physician & forwarded with the Referral Package to the 2<sup>nd</sup> Floor for review.  
Questions? Contact 1.780.594.9907

## Patient Information

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_  
Health Care # \_\_\_\_\_ Treaty # \_\_\_\_\_  
Patient Address \_\_\_\_\_  
Home Phone # \_\_\_\_\_ Cell # \_\_\_\_\_  
Primary Physician \_\_\_\_\_ Contact # \_\_\_\_\_

## Physician Consultation & Medical Review

Drugs of Use~ please indicate drug name, frequency/ duration of use & date of last use  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Withdrawal Symptoms~ please indicate drug & associated symptoms  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Significant Past Medical Problems~ please indicate diagnosed, treated & untreated conditions  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Received Date \_\_\_\_/\_\_\_\_/\_\_\_\_ INTERNAL USE ONLY Reviewed Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Revised 09/2018



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## Past Operations

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## Social History~ please indicate past/current alcohol/tobacco use

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## Significant Family Medical History

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## Clinical Examination

Height \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_\_

Birth Control  Yes  No Method \_\_\_\_\_

Date of Last Normal Period \_\_\_\_\_ Pregnancy Test Result \_\_\_\_\_

Is This a Planned Pregnancy  Yes  No Trimester 1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_ 3<sup>rd</sup> \_\_\_\_\_

Expected Date of Delivery \_\_\_\_\_

Have You Had Prenatal Care for This Pregnancy? \_\_\_\_\_

If yes, date of 1<sup>st</sup> Prenatal Visit \_\_\_\_\_ Location \_\_\_\_\_

Total Number of Pregnancies \_\_\_\_\_ Term Birth \_\_\_\_\_

Abortion \_\_\_\_\_ Miscarriage \_\_\_\_\_ Premature Birth \_\_\_\_\_ Stillbirth \_\_\_\_\_

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## General Inspection

### CVS

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### RESP

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### Abdomen

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### CNS

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### MSK

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### Urogenital

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### Current Prescribed Medications

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### Assessment/Diagnosis

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Treatment

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Name of Physician completing form

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Appointment Date

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Physician Signature

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Date Medical Assessment  
Form Completed

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Physician Contact Information

Received Date \_\_\_\_/\_\_\_\_/\_\_\_\_

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