



The 2nd Floor Women's Recovery Centre Referral Medical Assessment

This form must be completed by a Physician & forwarded *with* the Referral Package to the 2nd 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



The 2nd Floor Women's Recovery Centre Referral Medical Assessment

Past Operations

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

Significant Family Medical History

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 1st _____ 2nd _____ 3rd _____

Expected Date of Delivery _____

Have You Had Prenatal Care for This Pregnancy? _____

If yes, date of 1st Prenatal Visit _____ Location _____

Total Number of Pregnancies _____ Term Birth _____

Abortion _____ Miscarriage _____ Premature Birth _____ Stillbirth _____

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General Inspection

CVS

RESP

Abdomen

CNS

MSK

Urogenital

Current Prescribed Medications

Please provide a print copy of all currently prescribed medications.

Assessment/Diagnosis

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Treatment

Name of Physician completing form

Appointment Date

Physician Signature

Date Medical Assessment
Form Completed

Physician Contact Information

Received Date ____/____/____

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Reviewed Date ____/____/____