HOPE PLACE CENTRES FREEDOM FROM ADDICTIONS	**MEDICAL CLEARANCE FORM**	Name Catalyst #

Your patient has applied to Hope Place Centres for in-patient integrated addiction and stage one trauma treatment. We require the following information to assess whether they are physically and mentally healthy enough to successfully complete our intensive program.

PLEASE PRINT CLEARLY

Patient Name (first/last)	***D.O.B. (DD/MM/YYYY)***	***Health Card #***
Please indicate any substances used and/or medications that your patient has misused in the past year.		

	✓ ***yes***	***X no***
Does patient have any *life-threating* food/drug/environmental allergies? **if "yes" please detail below*		
Does patient have any *physical ability* limitations/restrictions or any *cognitive/mental health* limitations/restrictions?? **if "yes" please detail below*		
Does your patient have any history of seizures? **if "yes" please detail below*		
Does your patient have any history of self-injurious behaviour? **if "yes" please detail below*		

***Patient is NOT permitted to bring any medications/supplements with them into treatment; *TOTAL HEALTH* pharmacy will dispense and deliver weekly blister-packs for your patient to our facility directly. The TOTAL HEALTH Pharmacist will contact your patient pharmacy to arrange for necessary prescriptions to be sent directly to pharmacy via phone/fax.**

***PLEASE NOTE: Dr. Peter Eddenden, our facility physician will be contacting you directly for further patient information once admission planning is completed.**

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PRESCRIPTION MEDICATIONS (if applicable***) If you are currently prescribing an opioid or benzodiazepine to this client please attach additional information outlining the history of the medication, medical reason for the prescription and taper plan if applicable.

Drug Name/Reason Prescribed	Dosage	*Timing (+patient preference)*				
		AM	NOON	PM	BED	*PRN*
		AM	NOON	PM	BED	*PRN*
		AM	NOON	PM	BED	*PRN*
		AM	NOON	PM	BED	*PRN*
		AM	NOON	PM	BED	*PRN*
		AM	NOON	PM	BED	*PRN*
		AM	NOON	PM	BED	*PRN*
		AM	NOON	PM	BED	*PRN*

DOES YOUR PATIENT REQUIRE ANY OTC OR SUPPLEMENT MEDICATIONS? ***(* If yes, please list below:)***

		AM	NOON	PM	BED	*PRN*
		AM	NOON	PM	BED	*PRN*
		AM	NOON	PM	BED	*PRN*

_____ _____ _____

Pharmacy Name **Phone** **Fax**

_____ _____ _____

Physician or Nurse Practitioner Name *(*please print or stamp)* **Phone** **Fax**

_____ _____

Signature **Date** *(DD/MM/YYYY)*

PLEASE DO NOT GIVE THIS FORM BACK TO PATIENT

Completed form must be returned directly to us via fax or email. Contact us re: questions/concerns

FEMALE PATIENTS ☎ 905.465.1679 905.465.3321 intake@hopeplacecentres.org

MALE PATIENTS ☎ 905.465.3961 905.465.3321 admissions@hopeplacecentres.org