The Reverend Tommy Beardy Memorial
Wee Che He Wayo Gamik Family Treatment Centre
P.O. Box 131, Muskrat Dam, Ontario P0V3B0
Phone: (807) 471-2554 Fax: (807) 471-2510

Medical

Application for Admission

Medical application must be signed by the applicant. Forms that have not been signed, will not be considered for admission. Upon signing, you are agreeing to the following conditions for your treatment and healing.

- I will commit and dedicate myself to six weeks of treatment for my substance misuse.
- I will cooperate, participate and follow the Reverend Tommy Beardy Memorial Wee Che He Wayo Gamik Family Treatment Centre guidelines and house rules.
- I have been substance free for at least 30 days.
- I am ready to start and complete my treatment without distractions.

All that I have completed in this application is true to the best of my knowledge. I acknowledge that failure to comply with the above conditions will result in my dismissal from the program, at my own expense, upon the discretion of the Executive Director.

Signatures

Applicant's Signature	Date (YYYY/MM/DD)
Co-Applicant's Signature	Date (YYYY/MM/DD)
Witness's Signature	Date (YYYY/MM/DD)

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MEDICAL INFORMATION FOR THE APPLICANT

Please Note: This form is to be completed by a heath care provider.

ADDRESSOGRAPH

Name of Applicant:	
Date of Birth (YYYY/MM/DD):	

Please Note:

Unfortunately, we are unable to accept applications from individuals who are currently pregnant. Our community has limited facilities and is geographically isolated. The program is intensive and stressful, which we are concerned may harm the unborn baby and applicant. The applicant should wait until at least three months after the baby is born to apply.

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MEDICAL HISTORY

Does this person have any of the following medical conditions requiring treatment?

Medical Conditions	Yes	No	Description (list conditions)
Cardiovascular Conditions (Hypertension, Heart Disease, Stroke)	☐	☐	
Respiratory Conditions (Asthma, COPD)	☐	☐	
Mental Health Conditions (Depression, Anxiety Disorders, Bipolar Disorder, Schizophrenia, PTSD)	☐	☐	
Neurological Disorders (Epilepsy, Migraines, Traumatic Brain Injury)	☐	☐	
Gastrointestinal Conditions (Liver Disease, Gastritis, Pancreatitis)	☐	☐	
Endocrine Disorders (Diabetes, Thyroid Disorders)	☐	☐	
Musculoskeletal Conditions (Arthritis, Chronic Pain)	☐	☐	
Other Relevant Conditions (Kidney Disease, Cancer, Blood Disorders, etc.)	☐	☐	

MEDICATION

Medication	Form (capsule, tablet, liquid)	Dosage	Dosing Schedule

***It is important that the applicant has a 6-week supply available.**

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ALLERGIES

Allergen	Type of Reaction	Severity	First Noted	Notes

ACCESSIBILITY REQUIREMENTS

Does the applicant have any specific accessibility needs or accommodations due to physical, psychological or other disabilities?

Yes	No
☐	☐

If yes, please describe:

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COMMUNICABLE DISEASE INFORMATION

Communicable Disease	Condition and/or Treatment

*No applicant will be accepted until treatment has been completed or the contagious period is finished.

TUBERCULOSIS

Mantoux Skin Test	Date:	Result:

TB skin test is required if the client has been in contact with anyone with tuberculosis within the last three months.

Is the applicant currently undergoing anti-tuberculosis therapy?	☐ Yes	☐ No
Does the client have a history of untreated or incomplete tuberculosis therapy?	☐ Yes	☐ No

If yes, to either option, please describe:

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IMMUNIZATIONS

Are immunizations, including TB, Pneumovax and Fluzone, up to date?	☐ Yes	☐ No

If no, please provide the necessary vaccinations:

EXAMINATION FINDINGS/CONCLUSION

Describe any significant findings on examination:

Please provide any concluding remarks:

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This certifies that _____ is physically and mentally able to undergo treatment for substance misuse.

Health Care Provider's Name	Profession (MD, NP, LPN, etc)
Health Care Provider's Signature	Date of Examination (YYYY/MM/DD)

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MEDICAL INFORMATION FOR THE CO-APPLICANT

Please Note: This form is to be completed by a heath care provider.

ADDRESSOGRAPH

Name of Co-Applicant:	
Date of Birth (YYYY/MM/DD):	

Please Note:

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MEDICAL HISTORY

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Medical Conditions	Yes	No	Description (list conditions)
Cardiovascular Conditions (Hypertension, Heart Disease, Stroke)	☐	☐	
Respiratory Conditions (Asthma, COPD)	☐	☐	
Mental Health Conditions (Depression, Anxiety Disorders, Bipolar Disorder, Schizophrenia, PTSD)	☐	☐	
Neurological Disorders (Epilepsy, Migraines, Traumatic Brain Injury)	☐	☐	
Gastrointestinal Conditions (Liver Disease, Gastritis, Pancreatitis)	☐	☐	
Endocrine Disorders (Diabetes, Thyroid Disorders)	☐	☐	
Musculoskeletal Conditions (Arthritis, Chronic Pain)	☐	☐	
Other Relevant Conditions (Kidney Disease, Cancer, Blood Disorders, etc.)	☐	☐	

MEDICATION

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MEDICAL INFORMATION FOR THE CHILD

Please Note: This form is to be completed by a heath care provider.

ADDRESSOGRAPH

Name of Child:	
Date of Birth (YYYY/MM/DD):	

Please make copies, as necessary, for additional children.

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Musculoskeletal Conditions (Arthritis, Chronic Pain)	☐	☐	
Other Relevant Conditions (Kidney Disease, Cancer, Blood Disorders, etc.)	☐	☐	

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Allergen	Type of Reaction	Severity	First Noted	Notes

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Yes	No
☐	☐

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