Name:____________________
PHN: ____________________
DOB: ____________________

Return to Family Treatment Centre
1200 – 24th St West
Prince Albert, SK S6V 5T4
Phone: 306-765-6375
Fax: 306-763-4670
Nurse's office: 306-765-6377

Please print clearly, Medical will be returned if unable to read

Pre Admission Physical Examination Adult

Date: ____________________

Please check yes or no to indicate if the client is currently being treated for or if they have a history of any of the following

	Yes	NO	Please provide details
TB			
Heart Disease			
Mental Illness			
Epilepsy or Seizures			
High blood pressure			
Cancer			
Allergies			
Stroke			
Diabetes			
Chronic Pain			
Sexually transmitted infections			
Lung disease			
HIV/AIDS			
Hepatitis A B C			
Lice or Scabies			
Pregnancy			LMP: G: P:
Past injuries			
Physical limitations			
Special diet			
Current Medications ____________________ ____________________ ____________________		**Dose** ________ ________ ________	**Please ensure that your patient has sufficient refills on necessary prescriptions to encompass the six week treatment period. Prescriptions can be sent to the Medi-Center Pharmacy (PH: 306-763-2022 FAX: 306-764-0602)**

Physicians Name:________________________ **Physicians Signature:______________________________**

By signing this for, I give authorization for any medical information to be released by the physician

Client Signature______________________________ **Date:_________________________________**

Note: Please attach any necessary reports or lab results that you think may be beneficial

Name:____________________
PHN: _____________________
DOB: ____________________

Return **Family Treatment Center**
1200 24th St. West
Prince Albert, Sk. S6V 5T4
Phone: 306-765-6375
Fax: 306-763-4670

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Pre Admission Physical Examination – CHILD (one form per child)

Date:_______________________________________

Please check yes or no to indicate if the client is currently being treated for or if they have a history of any of the following:

	YES	NO	Please provide details
Tuberculosis			
Asthma			
Skin conditions			
Dental issues			
Allergies			
Lice or Scabies			
Frequent ear infections			
Hospitalizations			
Congenital disorders			
Neonatal Abstinence Syndrome			
Mental Health Concerns			
Past Injuries			
Physical Limitations			
Immunizations up to date			
Other (Please list):			

Current Medications ______________________ ______________________ ______________________

Dose _______ _______ _______

Please ensure that your patient has sufficient refills on necessary prescriptions to encompass the six week treatment period. Prescriptions can be sent to the Medi-Center Pharmacy (Ph: 306-763-2022 Fax 306-764-0602)

Physician Name: ______________________________ Physician Signature: ___________________________

By signing this form, I give authorization for any medical information to be released by the physician

Client Signature: ______________________________ **Date:** __________________________

Note: Please attach any necessary reports or lab results that you think may be beneficial

Family Treatment Centre- Saskatchewan Health Authority
Consent Form

Name:________________________D.O.B:_______________HSN:________________

I voluntarily consent to the exchange of verbal and written information concerning my condition and the services I received, for the purpose of my recovery and treatment, between PAPHR Family Treatment Centre and the following individuals and/or organizations:

✔	Organization	Name & Telephone	Email	Additions/ Date/Sign	Review date & Initial
	Addiction Services Outpatients Clinic				
	Indian Child and Family Services				
	Social Services- Child protection				
	Methadone Clinic				
	Physiatrist				
	Psychiatry				
	Family Physician				
	Mental health services				
	Social Services- Financial				
	School				
	Place of Employment				
	Early Childhood Intervention				
	Children’s daycare				
	Native Co-ord. Council – NCC				
	Pharmacy				
	Probation Officer				
	Parole Officer				
	Family-specific				
	Other:				