North Bay Regional Health Centre

Nipissing Detoxification and Substance Abuse Programs
Pre-Admission Health Form

This form must be completed by a physician or a nurse registered with The College of Nurses of Ontario

Surname:_____ Given Name: _____ Initial: _____

Date of Birth: _____ / _____ / _____ Age: _____ ❑ Male ❑ Female ❑ Other Marital Status: _____
day month year

Health Card Number: _____ Phone Number: (_____) _____

Address: _____
Street Apartment City Postal Code

➔ PLEASE COMPLETE FULLY, AS ALL FIELDS ARE MANDATORY ←

Risks Identified

- Diabetes**:** ❑ No ❑ Yes **Nicotine dependence: ❑ No ❑ Yes**
- High blood pressure: ❑ No ❑ Yes **NRT necessary – requires physician order**
- Communicable diseases: ❑ No ❑ Yes Specify _____
- Fall risk: ❑ No ❑ Yes Assistive device_____
- Allergies/Reaction: _____ Does the patient require epi pen? ❑ No ❑ Yes
- Please list below any other medical condition(s) not listed above:

HR:	BP:	HT:	WT:

Psychiatric History: (must be completed)	
Date last seen by Psychiatrist:	
Mental Health Diagnosis as per DSM V:	
Psychiatrist/Primary Staff:	Phone:
Prior to admission a phone consult / report may be necessary.	

Name: _____

CURRENT MEDICATION(S)
(Should you require more spaces please attach best possible medication history form)

All medications (prescribed, over-the counter medication, herbal, vitamins, minerals)	Dosage	Route	Frequency
Current daily medications:			
Current PRN and including: ❑ Epi pen ❑ Nitro ❑ Puffers			
Current elective OTC/Ancillary (vitamins/supplements/herbals):			
Nicotine Replacement Therapy (NRT): Physician's order required			

- **PLEASE COMPLETE ATTACHED PRE-PRINTED PHYSICIAN'S ORDERS (PPO) for use in the event that patient experience health complaints. Note: These will only be filled if required.**

Home pharmacy (name and number): _____ (_____) _____

Prescribing physician (name and number): _____ (_____) _____

If on suboxone or methadone:
Home pharmacy (name and number): _____ (____) _____

Prescribing physician (name and number):): _____ (____) _____

Name: _____

- Can person sit for increments of 45 minutes multiple times/day? ❑ No ❑ Yes
- Is client able to participate in daily educational sessions which require the individual to sit for extended periods and participate with others? If no, please explain: ❑ No ❑ Yes

_____

_____

- Learning difficulties / concerns: _____
- Able to read and write: _____

Please be aware that not all special diet requirements can be met.

- **Physician or nurse comments:**

Disclaimer: Please be advised that the balance of all medications will be returned to the patient in the event of an unscheduled discharge.

Date: _____ **Physician or Nurse:** _____

Print Name: _____

Please print: Information required to send discharge summary.

Physician or Nurse:	
Mailing Address:	
Telephone:	
Fax:	

Return completed form to

Central Intake
120 King Street West, Unit A, North Bay, ON P1B 5Z7
Phone: (705) 476-6240 Ext. 6290 • Fax: (705) 476-6136